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# National Rural Health Mission

## Project Implementation Plan Chhattisgarh

### 2010-2011

For Chhattisgarh  
Boo file (PHE)  
In  
22/1/2010



**STATE HEALTH SOCIETY**  
**DEPARTMENT OF HEALTH & FAMILY WELFARE**  
**CHHATTISGARH, RAIPUR**







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# NRHM PIP 2010 – 2011

## Introduction

Chhattisgarh carved out of Madhya Pradesh came into being on 1 November 2000 as the 26th State of the Union and now it is going to finish 10 years. It fulfils the long-cherished demand of the tribal people for having their own state. The state of Chhattisgarh has an area of 1, 35,191 sq. km. with 18 districts (two of them, Bijapur and Narayanpur being created recently), 146 blocks, and 20308 villages.

It is one of the few landlocked states of the country. Uttar Pradesh and Bihar bind the State in north, in the east it is bound by Orissa, in the south by Andhra Pradesh and in the west by Madhya Pradesh and Maharashtra. A large part of the state comes under Vindhya range that divides the Indian subcontinent into two. The middle part of the state is mostly plane land while both the northern and southern parts are largely plateau area covered with dense forest. Mahanadi and Narmada are the principal rivers of the state. The main crop of the state is paddy which is cultivated only once in a year due to dependency on rain.

## Situational Analysis:

The state's current demographic and health profile is given in the table below against the status of prior years:

**Table: Demographic profile -State versus India**

Indicator	India		Chhattisgarh	
	2000	2008	2000	2009
Population in million	1027**	10286.1	20.79**	244.00
Population Share (%)	100	NA	2.02**	NA
Population Density	324	312	154**	154
Female Literacy Rate 2001 (%)	54.28**		52.4**	
Rise in Female Literacy Rate since 1991 (% points)	15**		24.88**	
Sex Ratio	933**	933	990**	989
Tribal Population (%) (SC + ST population.	NA	NA	43%**	43.4



IMR Rural	74	64	61	58	95	65	61	59
IMR Urban	44	40	37	36	49	52	49	48
Birth Rate Total	25.8	23.8	23.1	22.8	26.7	27.2	26.5	26.1
Birth Rate Rural	27.6	25.6	24.7	24.4	29.2	29	28	27.6
Birth Rate Urban	20.7	19.1	18.6	18.5	22.8	20	19.9	19.3
Death Rate Total	8.5	7.6	7.4	7.4	9.6	8.1	8.5	8.1
Death Rate Rural	9.3	8.1	8	8	11.2	8.4	8.5	8.5
Death Rate Urban	6.3	6	6	5.9	7.1	6.9	6.5	6.4
Natural Growth rate- total	17.3	16.3	15.7	15.4	17.1	19.1	18.4	18
Natural growth rate- rural	18.3	17.5	16.8	16.5	18.1	20.6	19.5	19.2
Natural growth rate- urban	14.4	13.1	12.7	12.6	15.7	13.1	13.1	12.9

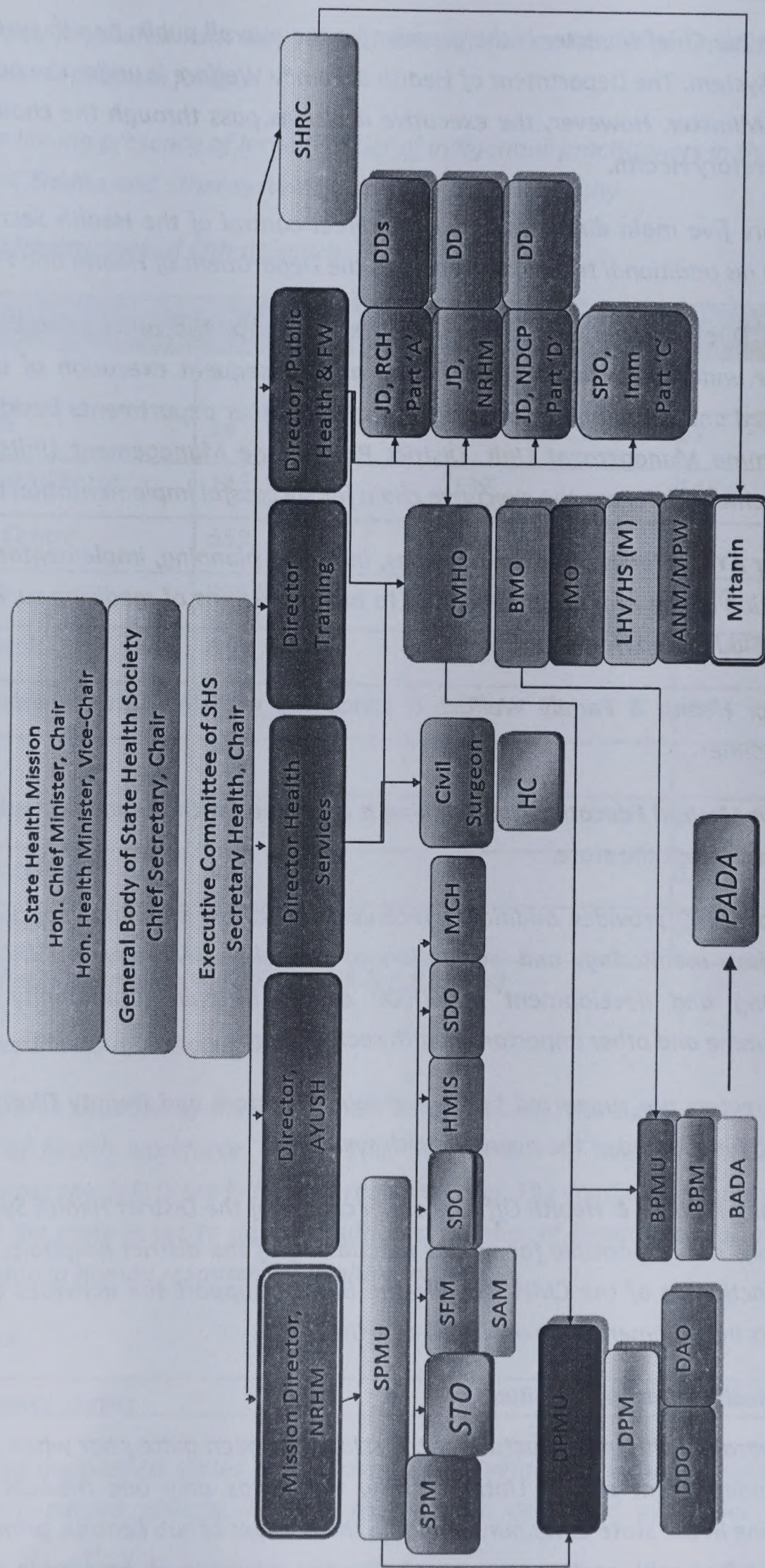
The Total Fertility Rate of the State is 3.4 a little high above the national level of 2.9. The Infant Mortality Rate for the state has come down currently to 75 from previous figure of 59 at the time of formation of the state. This is a major achievement for the state considering the fact that any reduction in IMR requires synergistic efforts from several departments and improvement in social status. The Maternal Mortality Ratio of 379 (SRS 2001- 03) is slightly higher than the National average (see the table below). The Sex Ratio in the State is 989 a favourable one, compared to 933 for the country. Comparative figures of major health and demographic indicators are as follows:

**Table: Administrative Profile of Chhattisgarh**

Administrative Units	Number
No. of districts	18
No. of blocks	146
No. of Gram Panchayats	9193
No. of Villages	20308

### Structure of Chhattisgarh Public Health System







The **Hon'ble Chief Minister** is the premier for the overall public health system of Chhattisgarh Health System. The Department of Health & Family Welfare is under the portfolio for the **State Health Minister**. However, the executive decisions pass through the chain of Chief Secretary and Secretary Health.

There are **five main directors** under the direct control of the Health Secretary. The Director, SHRC in his additional technical support to the Department of Health and Family Welfare.

Mission Director, NRHM is the principal authority for the tasks related to the mission. The Director undertakes the PIP formulation and subsequent execution of the plans with well-concerted and coordinated support from several other departments besides health. The State Programme Management Unit, District Programme Management Units, Block Programme Management Units are the executive chain for successful implementation of the PIP plans.

Director AYUSH looks after the activities, including planning, implementation, monitoring and evaluation of the programmes related to Indian systems of medicine such as Ayurveda Yoga, Unani, Siddha and Homeopathy.

Director Health & Family Welfare is concerned with the state health and family welfare programmes.

Director Medical Education and Training is concerned with the medical education and training activities across the state.

Director SHRC provides additional technical inputs for planning, policy formation, strategy execution, monitoring, and evaluation of the plans. Moreover, SHRC is involved in the nurturing and development of 60000 cadres Mitanin (Community Health Volunteers) Programme and other important health sector reforms.

The Directors are supported by several Joint Directors and Deputy Directors in effective and smooth functioning of the overall health systems.

The Chief Medical & Health Officers are in charge of the District Health Systems, while the Civil Surgeons are responsible for proper functioning of the district hospitals. The DPMU supports the functioning of the CMHOs while the BPMUs support the activities of the Block Medical Officers in implementation of NRHM activities.

### **The Health Infrastructure Situation**

The overall health infrastructure of the state has been quite poor when the state received its own independent status. Until recently, there was only one medical college for modern medicine in the state at Raipur. Similarly, the number of sub centres, primary health centres or community health centres were way below the requirement, keeping in mind that the state is



one of the sparsely populated with very remote and difficult to reach terrain with almost half of its land covered with dense forests.

The state is also having presence of large number of indigenous practitioners in the form of Ayurveda, Unani, Siddha and other systems along with Homoeopathy.

**Table: Health Infrastructure of Chhattisgarh**

Health Institution	Number (2007)	Number (2008)	Number (2009)
Medical College	3	3	3
District Hospitals	14	14	17
Community Health Centre	113	137	143
Primary Health Centre	659	721	716
Sub-centre	4164	4758	4776
Ayurvedic Hospitals	6	6	6
Ayurvedic Dispensaries	633	634	634
Unani Hospitals	0	0	0
Unani Dispensaries	6	6	6
Homeopathic Hospitals	0	0	0
Homeopathic Dispensary	52	52	52

(Source: RHS Bulletin, March 2007, M/O Health & F.W., GOI)

### **Health Workforce Status of Chhattisgarh**

The health workforce situation of the state is still in real dearth. The state is lacking in almost every category of health workforce. Worse still, the number of available nurses, doctors, specialists and super specialists are below the requisite level. The condition is further worsened by the fact that the state is yet to develop sufficient number of institutions for meeting this demand-supply gap in human resource for health services.

### **Other Challenges**

#### **Poor Socio-economic status**

The state is one of the poorest states of the country deserving to be included into the 18 EAG states. There is pervasive poverty, hunger, malnutrition combined with poor water and



sanitation services. Endemicity of malaria (9% of India's Malaria burden), leprosy, and continued political conflict adds to the woe further.

### **Difficult Geographic Location**

With large portion of the state either covered with forests or having plateau area with poor connectivity and transport systems is a major problem for referral services.

### **Vision and Goals for the Health Sector**

The Government of Chhattisgarh is committed to achieve the level of mental, physical and social well-being of its citizens through empowerment of local communities, framing of equity and gender sensitive policies, reduction of poverty, provision of comprehensive healthcare services. The Vision 2020 document of the state is in line with the Millennium Development Goals.

The state will be guided by the principles of transparency, accountability, community involvement, both the public, private, NGOs, to create a society allowing people to live their life to the fullest, fulfilling their social responsibilities and contributing to national progress.

### **National Rural Health Mission**

The National Rural Health Mission is a much welcome step for the state. It, along with support from European Union, fills the gaps left unattended or underserved by the State due to availability of limited resources. Mission's aims to provide universal access to equitable, affordable and quality health care that is accountable and responsive to the needs of the people, reduction of child and maternal deaths as well as population stabilization, gender and demographic balance is in line with the States Vision 2020 document.

### **Objectives of NRHM**

- Reduction of the IMR from the current 57 to 30 by the year 2012
- Reduction of MMR from current 379 to about 100 by the year 2012
- An increase of CPR to 65% by the year 2008 and reduction of total fertility rate to 2.1 and net reproduction rate to 1.0 by the year 2010
- Achieving IPHS norms of service delivery in all sub-centres, PHCs and CHCs and district hospitals by the year 2012
- Making maternal health, child health and adolescent health care facilities, safe abortion services and management of reproductive tract infections easily accessible to all



- Addressing the health issues in vulnerable communities like tribal population, urban slum population, people living in conflict areas etc.
- Effective outcomes on all disease control programmes
- Making Community level first contact care as well as necessary referral supports available to all
- Reduction of child malnutrition levels
- Ensuring effective Coordination within the health department as well as ensuring coordination with all sectors and programmes, which are determinants of good health
- Resolving the issue of finding skilled personnel to serve in medically underserved areas through implementation of an improved health human resource development policy and through appropriate public private and public civil society partnerships
- Decentralisation of health services and increased public participation in all health services and health management
- Professionalization of management at all levels
- Initiating community based monitoring and feedback system in order to improve the quality of public health interventions through triangulation of monitoring
- Mainstreaming of AYUSH systems
- Improving Medical Education along with tertiary level health care facilities in the state

The Mission envisages achieving these targets in a manner that is affordable to the community and equitable in distribution based on the varying needs of different strata of the population. The Mission aims to bring about a change in the health sector that is gender sensitive, taking care of the marginalised and vulnerable sections of the society, and people friendly.

### Systemic Inputs

#### Governance Reforms

Empowerment of Panchayati Raj Institutions and Improved Efficiency of Health systems are two cornerstones of National Rural Health Mission. The mission document envisages setting up a platform for involving the Panchayati Raj institutions and community in the management of primary health programmes and infrastructure; train and enhance capacity of Panchayati Raj Institutions (PRIs) to own, control and manage public health services. Further, it counsels



to strengthen existing PHCs through better staffing and human resource development policy, clear quality standards, better community support and an untied fund to enable the local management committee to achieve these standards. Integrating vertical Health and Family Welfare programmes at State, District and Block levels is another dimension of this mission.

To achieve all objective, department has selected nodal officers, as a core group of team leaders. They will be involved in supervising, mentoring and regulatory activities. Without such dedicated team leaders, delegation, devolution of powers and responsibilities will result in poor planning and implementation at lower levels. Chhattisgarh initiated several reforms in view of the above objectives. Some of the important ones are briefly described below.

### **Introduction of Commissioner System**

One of the key efforts of the state is appointment of a Health Commissioner at state level. The Commissioner will supervise and coordinate the activities of three state level Directors, viz. Directors of Family Welfare, Health Services and Health Training.

### **Strengthening of Directorates**

To improve the efficiency of the system at state level, three Directors have been appointed, viz. Directors of Family Welfare, Health Services and Health Training. Through this, each of the divisions shared heavy workload that previously bogged down the system, resulting in delay in plan implementation, poor planning and other administrative bottlenecks. The Director of Health Training has been especially created to take care of the ensuing heavy load of training and capacity building efforts in near future.

### **Filling up Positions of Joint Directors and Deputy Directors**

Five Joint Directors and Deputy Directors have been selected from the public health officials. They are supporting the Directors in integration of efforts, coordination among health divisions and with other departments.

### **Filling up vacancies of State Programme Management Unit (SPMU) and District levels staff**

Inadequate workforce was one of the major hindrances in programme implementation at all levels. Regular appointments were delayed for various posts under NRHM and Directorate of Health Services, Chhattisgarh. So, SHRC was entrusted with the task of Recruitment and Recommendations for Contractual Appointments. Recruitment process was conducted in 2009-10 and recommended lists were sent by SHRC to the concerned Departments for following vacancies:-



## **1<sup>st</sup> Phase**

- **CG State AIDS Control Society: 120 Posts**

*Counsellor-55, Lab Technician-53, Divisional Assistant-12*

- **NRHM : 216 Posts**

*Block Programme Manager-54, Block Accounts and Data Assistant- 52,*

*Hospital Administrator -15, Computer Programmer-3, Consultant and others-3.*

*Malaria Technical Supervisor-66, Lab Technician-33*

## **2<sup>nd</sup> Phase**

- **NRHM : 596 Posts**

- **State Level Posts: 8** (State Advisor- Demography Specialist-1, State Data Officer-1, State Procurement Officer-1, State Human Resource Officer-1, State Data Assistant-Immunization-1, Accountant-3)

- **District Level Posts: 124** (District Programme Manager-2, District Accounts Manager-6, District Data Officer-4, Accounts Assistant-94, District Data Assistant-18)

- **Block Level Posts: 464** (Block Programme Manager-92, Accounts and Data Assistant-350, Data Entry Operator-22)

- **NVBDCP: 27 Posts** ( GIS Data Entry Operator-1, Accountant-1, Secretarial Assistant-1, Insect Collector-2, Financial and Logistic Assistant-11, Data Entry Operator-11)

- **Leprosy Control Programme: 6 Posts.** (Data Entry Operator-6)

## **Devolution of Powers to Block Medical Officers**

*This is a bold step taken by the State. The Block Medical Officers have been given the power of Drawing and Disbursal Officer. Through this measure, more decentralized decisions making on health activities and quick fund release and utilization have been materialized. This effort will bear fruits after sometime and then it is likely to be held as key step in decentralised planning and implementation process.*



## **Electronic Procurement and Funds Transfer**

Establishment of electronic procurement and electronic funds transfer are signal events in health sector reform of the state. E-tendering and procurement of equipments, drugs and such other items will help to promote transparency, speediness with simultaneous involvement of vendors from across the nation. So far, e-tendering has been adopted for Health Management Information System, selection of Insurance Company for Rashtriya Swasthya Bima Yojana, Medical Mobile Units, and Drug & Equipment procurement.

## **Revision of Essential Drug List**

Rational use of drugs is a burning issue dogging the nation. To overcome the issue Chhattisgarh had formulated an "Essential Drug List" in 2002. However, the drug industry is a rapidly evolving industry and needs constant updating. Thus, an initiative was taken with assistance from State Health Resource Centre, Medical Colleges and select Peripheral Medical Officers to revise this list. The revised essential drug list, in year 2007, contains total 350 drugs and consumables and it has been endorsed by the Government.

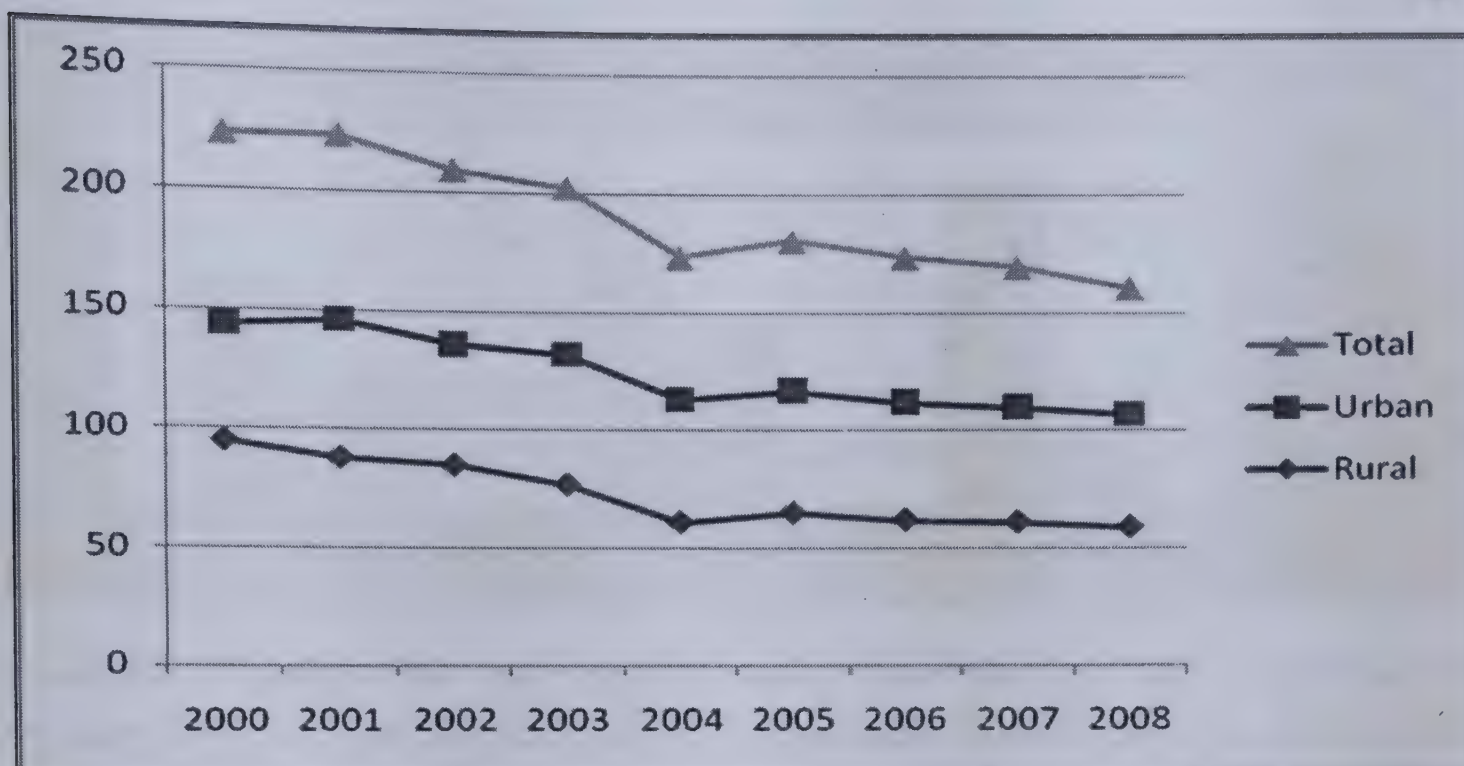
## **Integrated Health Equipment Management System**

Health sector is mainly a service sector with 60 – 65 % of the cost going for remuneration. However, 25 – 30 % of the cost is spent on drugs and equipments. Therefore, this area offers an opportunity to undertake measures for cost containment. Keeping this in mind, the Chhattisgarh Health Equipment Management System has been created as a part of an integrated inventory management system. There are one State Cell and two regional workshops under this system. This system is taking care of rationalized procurement, immediate repair of small equipments, supervising the annual maintenance contract for costly equipments. Moreover, this system is undertaking capacity building measures to improve the skills and knowledge of different cadres of technicians in preventive maintenance and repair.

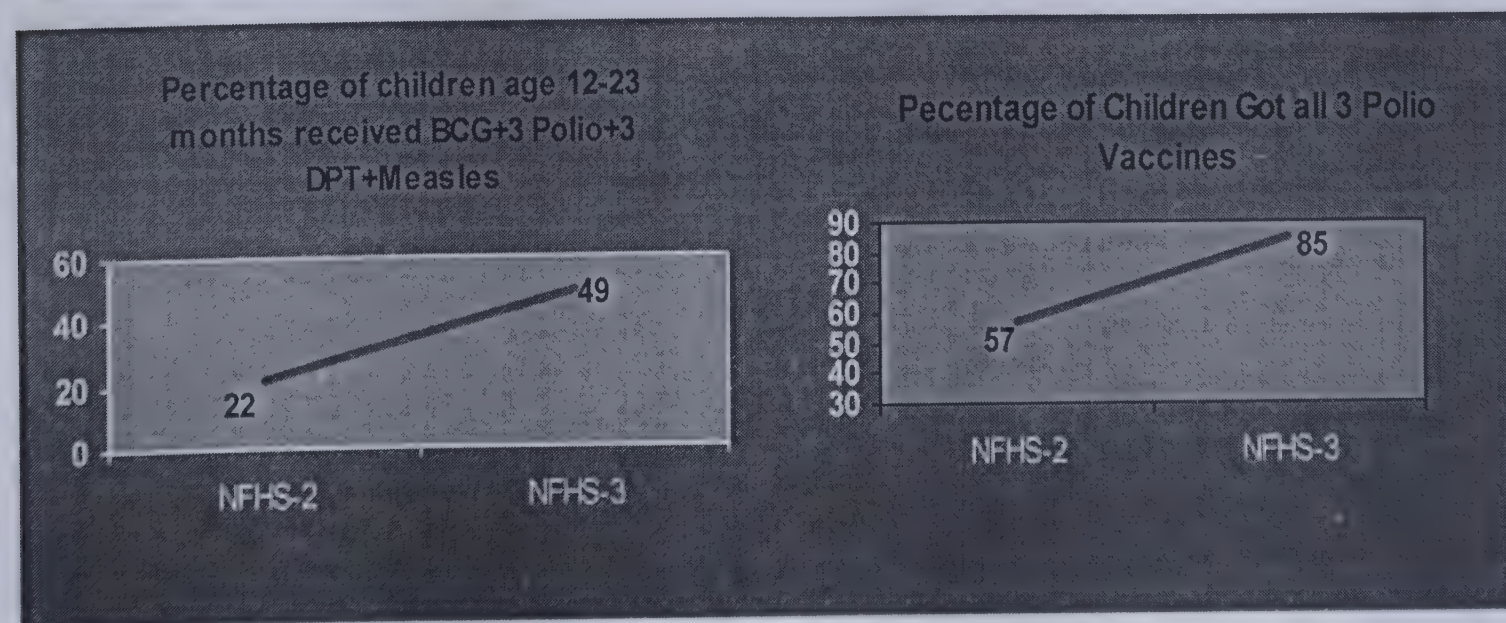
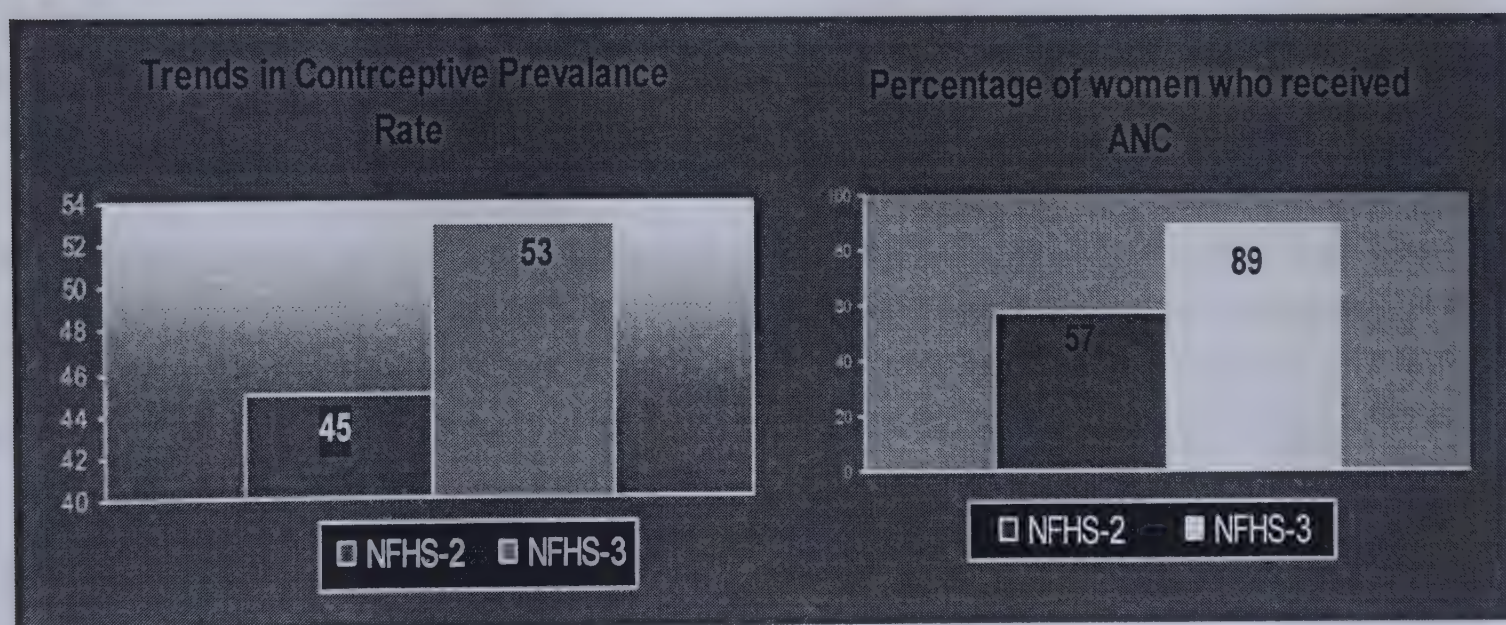
## **Summary of Health Sector Achievements**

After the state formation, health sector reforms in the state have been given a major thrust and the state has achieved stupendous success in bettering basic health indicators, in ensuring quality health services and in improving the public health infrastructure. The rural infant mortality rate has registered a major decline during this period. In 2003, the Rural IMR was 77 per 1000 live births whereas presently it is 59, which is equal to the national average. The growth has also been tremendous in the health services scenario. The Comparison of National Family Health Survey-2 during formation of the state and the NFHS-3 with the very recent status gives a testimony to this growth.

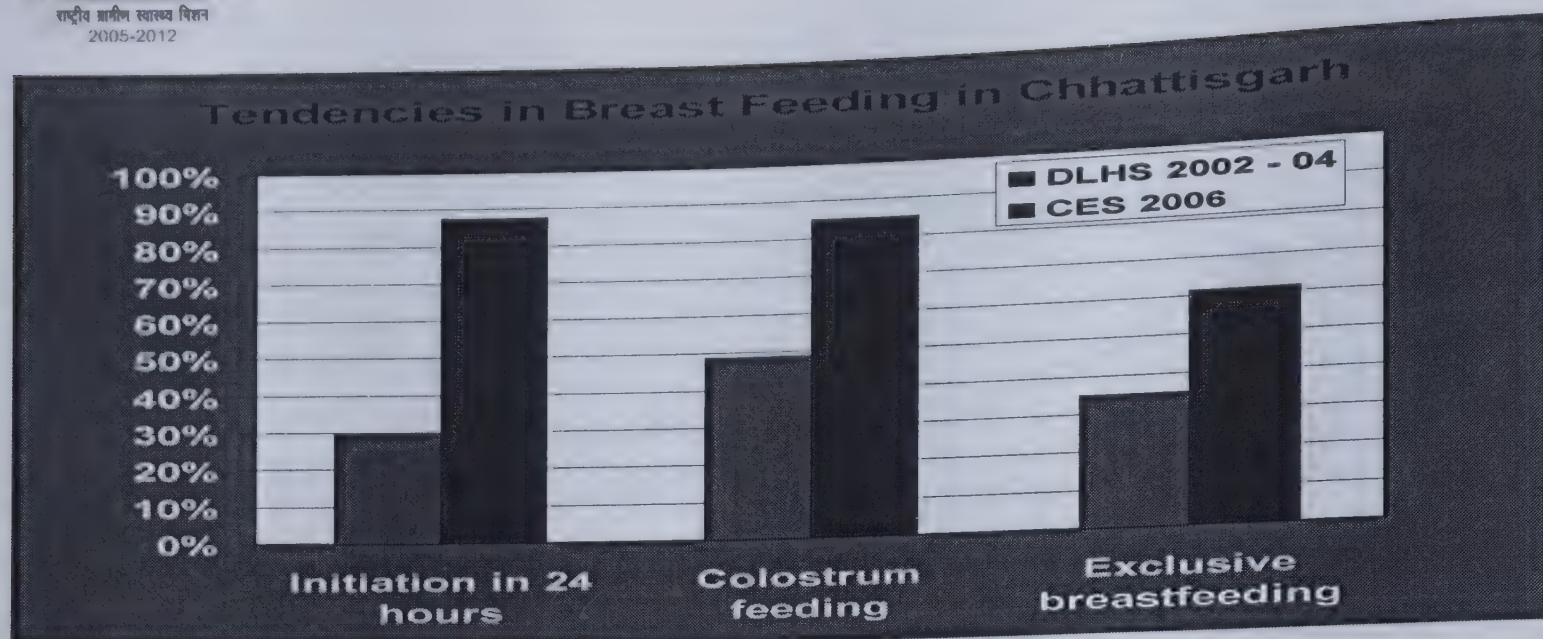




### 1.10.1 Comparison of Key trends under NFHS-2 and NFHS-3:







It could also be seen that the health service indicators like Contraception prevalence rate, women receiving ANC, Children receiving full immunisation has improved in a much visible manner and malnourishment among children has decreased. An independent evaluation done by UNICEF and the District Level Household Surveys also project a very good improvement of health services in the state. One of the major community level achievements marked is the growth in breastfeeding- the colostrums feeding, early initiation of breastfeeding as well as exclusive breastfeeding- that has extreme potential in reducing the neonatal mortality. This was the result of comprehensive community level health education drives that the state government was able to gear up through various measures like folk art based communication programmes followed by good service delivery together by health department staff and Mitans. Another achievement has been the reduction of malnourishment among children below 3 years- credit of this goes to the interdepartmental coordination that was key agenda of the government.

Apart from above, the state was able to record major achievements in disease control - like:

- **Yaws** - Disease of the underdeveloped areas- has been eliminated from the state and it is marching towards eradication. There were 15 identified cases of Yaws were there in the state in 2003, whereas within a year, this was brought down to zero. The Chhattisgarh efforts on this has been highly appreciated by World Health Organisation and our officials are now been invited to support the Yaws operations in countries like Indonesia.
- The **Polio** scene has also been controlled very well during this period. During the initial days of the state, a threat of polio was prevalent as some cases were reported in the state during that time. With effective surveillance systems, management and immunisation initiatives, the disease have been prevented as much as possible and "no case" has been reported till date.



- **Leprosy** is another disease, which is reaching the elimination stage. In 2003, the prevalence rate was 7.20 per 10000 populations, which have been brought down to 1.99 through persistent efforts. In 6 out of 16 districts, national goal of less than 1 prevalence rate has been achieved and the remaining districts are moving quickly to achieve this.
- Towards achieving better impact of **TB** control programme, the first step that the State adopted was to expand the programme to cover all 16 districts whereas it was covering only 4 districts earlier.
- In **Malaria** control, the major achievement is the very efficient level of control in malaria epidemics- this is despite the fact that the state is highly endemic if compared to any other state of the country. The death tally, which was 98 during the period 2000-03, has been brought down to 15 in the last 3 years. The Annual Parasite Incidence, which was 10.6 in 2003, has been brought down to 5.6 as result of the dedication rendered by the Health Department. Still, three of the southern districts where API is high are under high focus.
- Towards Controlling **HIV/AIDS**, the awareness programmes as well as voluntary counselling/testing has been optimised. Effective target intervention as well as blood transfusion facilities has been achieved as well as the state was able to successfully negotiate for making ARV treatment available for the state which was not available till 2004. 52 Integrated counselling and treatment centres and 33 STD clinics initiated. Initiation of state of the art model blood bank and the constitution of state blood transfusion council are also notable achievements.
- The Scenario of **Blindness** control has improved to one of the best programmes of the country during this period. We could initiate a Public Private Partnership also, in the area of advanced eye care, with **MGM Eye Institute**, Raipur.
- In order to make **advanced health care facilities**, especially cardiac surgery, available to the people, the MoU with **Escorts** hospital was renewed with more pro-poor clauses and conditions. Similarly, a new 100 bedded cancer hospital is coming up in Raipur as a joint venture with **Vedanta**.
- A special programme to control **Sickle Cell Anaemia**, a specific disease prevalent in the state is also being run. Operational research, mass screening and counselling as well as other measures initiated where support from Red Cross society is also availed.
- An **Integrated Disease Surveillance Programme** has been launched in order to sharpen the operations related to disease control initiatives.



- **The Reproductive & Child Health Programme** as well as **National Immunisation Programme** also has been implemented by the state with utmost priority. Under **Janani Suraksha Yojana**, the institutional delivery level has gone up which was about 33 % earlier and further major hike is expected during this year. All these achievements are results of better planning, of optimum use of technical efficiency and of bringing together all stakeholders. The government has taken major initiatives to improve the community participation in health, quality of health care services as well as adequate health infrastructure and manpower provisions. An innovative institutional model has been set up in the form of state-civil society joint initiative, the **State Health Resource Centre** to shape the reform processes and to initiate them wherever it is necessary. Some initiatives that the state took are widely appreciated, like:
- **Optimising the Community Level Measures – The Mitantin Programme:** The Mitantin Scheme of community based health services, what began as very small community level project has become a model and path paver scheme for the entire country. The scheme has undergone a major expansion during the last few years to a massive coverage of about 60000 Mitantins or voluntary health activists who are giving their voluntary services in every hamlet and in every nook and corner of the state. They have undergone 10 rounds of trainings including the one on integrated management of neonatal and childhood illnesses and giving first level curative care using Mukhyamantri Dawa Peti Scheme. The Mitantin Scheme has been grown to such a level during this period that it influenced the design of ASHA (Accredited Social Health Activist) scheme under the National Rural Health Mission launched by Government of India.
- **Improving Performance of the Hospitals - The Jeevan Deep Approach:** In order to improve the quality of management of the government run hospitals and to change the perceptions of general community about the poor quality of services in government hospitals, a pioneering hospital reform scheme called the Jeevan Deep Scheme has been put in place in the state. Under this novel scheme a more responsive, more representative, more people oriented and more target centric hospital management committees called Jeevan Deep Samitis have been created for every level of government hospitals upto the PHC. These committees will also have the power to recommend disciplinary action against non-performing officials. Under this scheme, every hospital in the state will be graded based on its service quality and best hospitals will be given Jeevan Deep gold stars, silver stars and bronze stars respectively. The best hospital in every district will get Rs. 2 Lakhs as reward for good services. Chhattisgarh is the pioneer state to have launched such a peoples friendly target oriented scheme. It



will be a marked departure from the old Rogi Kalyan Samitis, which were running the hospitals earlier. Korba, Ambikapur and Durg are Silver Star hospitals. The Korba District Hospital has been certified for ISO 9001:2000.

- **Developing FRU facilities and bridging specialist gaps: the Equip Initiative:** In terms of closing the gaps in infrastructure, skilled manpower and equipment in parallel to addressing quality and adequacy of utilization of services, a new block by block approach has been adopted by the state. This approach goes by the acronym "EQUIP"- Enhancing Quality in Primary health care- and it focuses on reduction of maternal mortality as the quality index around which health services are rationalized. 32 blocks each has been taken up in the first two years and the entire state is planned to be covered in another 3 years. So as to address the specialist gaps, an innovative training programme for multiskilling doctors, particularly in EmOC and Anaesthesia, has been designed which has been replicated nationally now. These trainings are conducted in 3 top medical institutions of the state and so far 96 MBBS doctors has been built capacities to impart EmOC services as well as anaesthesia. Training on essential neonatal care and some other disciplines are also started very recently. This way the FRU service provision has been marked a much better status in the state if compared to past- We would like to note that these facilities are now becoming available even in some of those facilities situated in conflict-ridden areas of the state.

#### **Rationalisation of Human Resource for Deployment :**

##### **Strengthening Human Resources in Health Sector: Rationalization of Postings**

- **Malady:** Several doctors with post graduation or multi skilled in EmOC or Anesthesia skill are wrongly posted in PHCs.
- **Solution:** Relocation of Specialist doctors after counseling to improve Specialist Care in referral institutions

The issue of laying down a transparent and rational posting of Doctors in the government service has been gaining the attention of the state Government for quite some time. Lack of a fair and non-discriminatory transfer and promotion policy has resulted in the lack of motivation of doctors who have already completed dedicated service in the periphery. In many states in the country whimsical transfers and postings by different committees/authorities influenced by political leaders had taken place at different periods. How to prevent this has been a challenging task of Human Resource Management under Health Sector reform agenda of the country.



Even in the Department of Health and Family Welfare, Chhattisgarh, it is alleged that there is irrational placement of doctors including specialists, which was also the observation of Joint Review Mission under RCH program and the Common Review Mission of NRHM GOI. The current government is committed to correct this anomaly. Hence the need to formulate a new posting as well as rationalization of doctors cadre. Equally important is to enabling career advancement path.

As per the National Rural Health Mission all CHCs with population coverage above 500,000 are to be upgraded as First Referral Unit (FRU) at sub district level in a phased manner for Comprehensive Emergency Obstetric Care or four FRUs per average district with approximately two million population. These FRUs should have one Physician, Surgeon, Pediatrician and Gynae & Obst. as per IPHS norms.

Under NRHM, adequate funds are available for improvement of existing infrastructure and supply of necessary equipments as per IPHS norms. A number of infrastructures have been already developed so as to provide specialist services and emergency health care to the people especially in the rural areas. But the most daunting task is to ensure availability of qualified specialists. Considering all this aspects in the state, department decided to operationalize the selective health facilities to improve the service delivery and better coverage.

**The objectives of rationalisation of human resource are:**

1. To ensure posting of all specialists in the district hospitals as per norms.
2. To ensure one Gynecologist and one Anesthetist specialist or EmOC/LSAS trained Medical Officer in each Community Health Center.
3. To ensure posting of one lady Medical Officer in each Community Health Center.

**To fulfill the above objective following strategies were adopted and implemented with full political and administrative commitment, first time in history of Chhattisgarh Government:**

1. Listing of excess Specialist doctors and/or Medical Officer on the basis of last in first out principle.
2. Institution in which the total posted Medical Officer are more than the total sanctioned posts, considered as the excess posts for rationalization.
3. In the whole process of the rationalization of human resource, high priority is given to Specialist doctors.
4. Posting of PGMO against the regular post of specialist in case the post remain vacant after rationalization of specialists



5. In case post remains vacant even after rationalization of Specialist doctors and PGMO in their specialization, nomination will be invited from the newly selected eligible specialist from the Public Service Commission.
6. No specialist doctor or PG Medical Officer will be posted at the PHC level.
7. All the specialist doctors or PGMO posted in PHCs will be compulsorily posted in the district hospital or Community Health Center as per the vacancies.
8. No posting of second Medical Officer in the PHC unless each PHC filled with one Medical Officer.
9. No Specialist doctor or PG Medical Officer or Medical Officer will be relieved from the place of posting unless another substitute report for duty in the facility.

**Process adopted:-**

1. Director of Family Welfare prepared the list of vacancy for specialist doctors and the list of excess specialist against the sanctioned posts.
2. Options invited from the excess specialist doctors against the vacant post and counseling for the post undertaken. In case there was no option for a particular vacant post, decision was taken on administrative ground.

**Progress so far:-**

Sr. No.	Cadre	1 st Round Counseling	2 nd Round Counseling	Total Number Doctor Reallocated
1	PGMO Surgery	4	2	6
2	PGMO Gynecologist	3	3	6
3	CHILD Specialist	1	1	2
4	PGMO Pediatrician	6	3	9
5	PGMO Anesthesia	3	0	3
6	EmOC Trained (Multiskilled)	2	4	6
7	LSAS Trained (Multiskilled)	1	2	3
	<b>TOTAL</b>	<b>20</b>	<b>15</b>	<b>35</b>



**Currently new recruitment through public service commission, posting done on the basis of rationalization strategy-**

Specialist	District Hospital	Community Health Centre	Primary Health Centre	Civil Hospital	Total
OBS/Gynaecology	6	4	0	1	11
Surgeon	2	0	0	0	2
Medicine	1	5	0	0	6
Paediatrics	4	8	0	0	12
Anaesthesia	5	3	0	0	8
Ophthalmic	4	0	0	0	4
ENT	5	0	0	0	5
Radiology	2	0	0	0	2
PSY	1	0	0	0	1
Radiotherapy	1	0	0	0	1
Skin	1	0	0	0	1
Orthopaedic	4	2	0	0	6
Pathology	2	0	0	0	2
Total	38	22	0	1	61

MBBS doctors have been given posting at PHC level facilities.

### **New Initiatives and activities in HMIS/M&E :-**

#### **1. Printing of new forms and Integrated data capture register**

- For beneficiaries wise maternal and child tracking village wise new integrated MCH register have been designed and printed which includes all the data elements of HMIS reporting format till sub centre. This will reduce the number of registers in the sub center and also smoothenng the sub center level reporting system.

#### **2. Online application development**

- To fulfill the state specific requirement regarding review of programme implementation like Human resource, Infrastructure, monitoring reports etc. Four Programmers has been appointed @Rs.18000/- per programmer to develop all these requirements with the help of NIC, Chhattisgarh.



- Online daily monitoring reporting system has been started from District Hospital and CHC. The TOT was held at state level. Subsequent training was held at district level. The data entry of the District Hospital was started in August 2009. The CHC level data entry started from Sep. 2009.
- On-line monitoring formats entry have been developed wherein the Officers posted in the State, District and below levels can visit the institution and fill in the formats of CHC/PHC/SHC and VHND formats.
- Infrastructure MIS – the data entry formats are being developed to capture the information related to how many centers are running in govt. bldgs, and other information of availability of labour room, toilets etc.
- Manpower MIS - the data entry formats for the personnel employed in each of the institutions, and their basic information related to place of posting the pay scale etc. To capture the information related to transfer and promotion of the employees provision is made.

### **3. Computerization up to PHC level**

- In 2010-11 all the PHC will be computerized. A proposal of purchase of 370 more computers to be purchased and to be supplied to all PHC. In all the PHCs one Data Entry Operators will be posted.

### **4. Training of staff in new HMIS**

- In current financial year all the person related to Data reporting system beginning from PHC to State level will be given training on HMIS. The training on DHIS2 & HMIS Sub-Centre level format data entry training will be given to all the NRHM District and Block level staff. For the capture of beneficiary wise information a Desktop ANM Register capture software is being developed. In the later stages the desktop data will be transferred to the On-line web portal. Entry in this software will be done in all the PHCs where computers have been provided. The other centers where there are no building and computers the entry would be done in the nearby PHC or CHC. Budget of Rs.500,000 lacs @500/- per person for 1000 computer personals is proposed in this financial year.

### **5. Review meetings**

- For monitoring the progress of the activities monthly and quarterly meeting are to be conducted at state, divisional, district and block level. State level review meeting are personally chaired by Hon. Health secretary and Mission Director, District level



meetings are reviewed by CHMO, DHO, CS. Block level meetings are conducted by BMOs and sector level review meeting are taken by supervisors.

## 6. Field visits

- Review of quality of service delivery and utilization etc is most important part of M & E & through routine visits. Monitoring formats at all level from sub Center to District Hospital is designed and implemented. Nodal officers are appointed at state level Joint Director/Dy. Director, at District level CMHO, DPM and Programme officers and at Block level BMOs and BPM are designated as a nodal officer for monitoring activities. Also Nodal officers for each of the component of RCH activities/NRHM activities have been assigned the job to monitor the quality of service delivery and utilization including through field visits.

## 7. Web Base information management System

- New web site for Health Department is designed in which all the important correspondence and guidelines will be incorporated and updated on a regular basis. All the demographic and statistical information of all the programmes have been uploaded. The information of state specific programmes information is also given. The National level newly started programmes of RSBY and JSY have been given due importance. All the guidelines and instructions to the district and block level would be uploaded regularly.

## 8. Promoting career pathways of Mitans:

- SHRC has provided conceptualisation and handholding support for admission and sponsorship of Mitanin volunteers into BSc (Nursing), ANM and GNM courses.

## 9. Formation of State Health Mission and Driving towards the NRHM Goals:

- Moving towards health for the poor, a state health mission has been constituted under NRHM, Chaired by the Hon. Chief Minister. State, District, and Block programme Management Units are supporting the mission activities at respective levels. Decentralised planning and management of resources to address local needs has become a reality.

**10. Visions and Policies:** Taking all stakeholders on board, the State health & Population policy has been prepared and this shall be notified soon. In addition, Vision-2020 for health sector has been adopted. A new act for regulation of clinical establishments under private sector is drafted and awaiting approval.



11. **Major Infrastructure Expansion:** The state has taken historical initiatives to expand the health delivery infrastructure in the state. Inadequate infrastructure being a major gap faced by the department, filling this has been accorded highest priority. The inadequacy in number of facilities has been met during this period by sanctioning health facilities: apart from all districts sanctioned of district hospitals, 17 new Community Health Centres, 200 new Primary Health Centres and 874 new sub centres has been sanctioned. By this, the state has achieved population norms except in the case of CHCs. In terms of filling the building gaps, 26 CHCs, 39 PHCs and 201 sub centre buildings are under construction. During the last 3 years, Rs 20 Lakhs per block allocations are made under various schemes for refurbishment of available buildings in all 146 blocks. The major focus under the European Union State Partnership is infrastructure development.
12. **Creation of the State Institute of Health & Family Welfare:** A Human Resource Development policy for health has been adopted and SIHFW has been created to take forward the implementation of this policy. A state of the art building for SIHFW has been completed and the institution has given adequate manpower and logistical support in terms of achieving its goals. It is aimed that the capacity and motivation gaps among the field force be addressed through systematic planning and implementation of training programmes initiated by SIHFW.
13. **Successful Negotiation for European Union Assistance:** The state was able to get 52 crores assistance for the health sector improvements in the state.
14. **Raising Medical Education Levels:** In the area of medical education, a promising scene has been created. One more medical college has been opened in Jagadalpur and another one for the northern part of the state is under consideration. The existing Medical College of Raipur has been given all necessary technological inputs as well as institutional support so as to develop it as a state-of the art medical institute of the area. Rapid allocations and steps have been made for the completion of the new building for Dental College. An attractive land policy is at the final stage in order to motivate non-governmental players to start new medical/nursing colleges and super speciality clinics. A Medical University to lead entire medical education arena within the state was also realised this year.
15. **Mainstreaming of Indian Systems of Medicine:** The Indian Systems of Medicine has been given top priority by the state. Initially the Raipur Ayurveda College was declared as a model Ayurvedic College with maximum funding and logistic support ended up ultimately as an Ayurvedic University. Pharmacy as well as drug testing facility for Ayurveda is available in quite a few states of the country as on now, and Chhattisgarh is one among them. Panchakarma therapy centres and speciality clinics have been started in a number of Allopathic health facilities so as to provide choice for the community. As many as 86



Primary Health Centres and Ayurvedic Dispensaries have been merged. All 60000 Mitanins are being trained on household herbal remedies. "AyurvedGram" concept has been developed to popularise Ayurveda based lifestyle practices.

**16. Control of Food & Drugs:** Achievements are many in the area of Food and Drugs Control also. A state of the art Drug Testing Laboratory is waiting inauguration at the heart of Raipur city where it was necessary to sent food/drug samples to external laboratories for getting the sample tests done. In addition to this, mobile laboratories have been made operational in order to make collecting samples from remote and village areas possible. Smoking and tobacco use has been banned in public places.

**Table: Comparative chart on health-showing growth on various interventional areas**

Area	Status 2003	Status 2009	Purpose/Achievements
<b>Policies and Programmes</b>			
Policy for Rationalisation of Human Resource		Finalised and approval	Human Resource Deployment
Health and Population Policy	Nil	Finalised, awaiting approval	Policy Governance
HRD Policy	Nil	Notified	Planned HR Development
Drug policy	Nil	Finalised, awaiting approval	Towards rational drug use
Policy for Medically Underserved Areas	Nil	Under Preparation	Reaching the unreached
Delegation and decentralisation of powers	Upto District	Upto Block	Grassroots governance
Mainstreaming of AYUSH	Not done	Achieved	Holistic approach
Yaws Control (No. of cases)	15	0	Towards Elimination
Polio Control (No. of cases)	2	0	Towards elimination
Leprosy Control (Prevalence Rate)	7.2	1.99	72.36 % reduction
TB Control (District Covered)	4	16	100 % coverage



Mitanin Programme (No. of Mitansins)	Nil	60092	100 % coverage of rural areas
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### 17. Creation of Buildings:

There has been acceleration in creation of buildings also. Taking funds from various sources – 47 CHC buildings have been built to norms and funds are available for another 82 buildings (from SIP, state funds, and NRHM). At least we can reach the minimum infrastructure needed for the creation of functional FRUs immediately for these CHCs, though it may take some more time to meet IPHS norms in all. The enormous gap in sub centre buildings of over 2800 sub centres has also been reduced to 1932 by this year through pooling funds from various sources. Given the fact that we are to move towards two ANM sub-centres and institutional delivery at every sub-centre, this still continues as a challenge. In PHCs, also, there is a substantial gap of 382 that need to be built- this includes the newly sanctioned ones. Other than health facilities, we need a district training centre in 12 districts and an office for the chief medical officer and district health society in 14. (the current data needs to be collected for the district action plan)

To address human resource gap in future state has plan to start 15 New Nursing College attached with District Hospital which will produce Total 750 student / Yr. Along with this 10 ANM school attached with District hospital and Vocation training 10 + 2 and ANM dual certificate course will start soon . More than 50 percent of the assistance availed under EU-State Partnership Programme has been allocated for addressing infrastructure gaps which shall be used in tribal and sc dominant areas. For rest of the areas, further possibilities needs to be explored.

**Table: Current Infrastructure Situation:**

Facility	Current Position	Need according the Population	Gap	Govt. Build.	without building	Year 2009-10 Sanctioned and Balance
Sub Health Centre	4741	5049	308	1742	2999 under Construction 1475	Sanct. – 557 Gap –967
Primary Health Centre	721	721	0	346	375 under Construction 240	Sanct. – 102 Gap - 33
Community Health Centre	136	201	29 (18 District Hospital +18 Civil	129 56 (30 bedded) 73 (10	7	Sanct. – 0 Gap - 7



			Hospital)	bedded)		
District Hospital	18	18	0	15	3	Sanct. – 2 Gap – 1
Medical College	03	6	3	3	0	NR
Dental Medical College	01 + (3 Pvt)	4	0	4	0	NR

### 18. Human Resource Situation:

The state has shown considerable growth in filling the human resource gap as well. The new staff setup has been sanctioned to match the requirement of new situation and permissions have been given to fill the gaps. The crunch on this as on today has been to get adequate number of doctors and paramedics. Timely promotion of various cadres of staff like from medical officers to specialists to administrative cadre as well as of paramedical staff and other workers to next level of seniority continued to be a problem and this has been given sufficient attention very recently. Almost all due promotions except that of the top order has been completed- 161 ANMs to LHVs, 354 MPW (m) to Supervisors, 16 Nursing sisters to matrons, 250 MOs to Specialists, 15 Senior Medical Officer/Specialists to DHOs, 8 DHOs to CMHOs. Similarly, posts of 1200 doctors, 162 staff nurses, 150 radiographers, have been advertised very recently. This way, the workforce situation indicates a growth, though still there are major gaps to fill. The numerical situation on this is as following:

**Table 1.12: Workforce status**

Post	Sanction	working	Vacant	Annual output in the state
Medical Officer	2147	1109	1038 MBBS –144 BAMS - 225	200
Specialist	701	248	453	50, promotions
Staff Nurse	935	866	69	168
Radiographers	153	99	54	50
Lab Technicians	731	357	374	100
Ophthalmic Assistant	620	295	325	100



Pharmacist	974	614	360	100
Dresser	936	630	306	

Post	Sanction	Regular existing staff	Vacant	Annual output in the state
Male Supervisor	872	722	150	promotions
MPW (Male)	4784	2514	2270	200
MPW (ANM)	5653	4984	669	500
Nursing sister	185	39	146	100
L.H.V.	1034	749	285	promotions
Rural Medical Assistant	398	303	95	Total availability – 1100 Course terminated.

**Table 1.13: Progress on training and skill development front**

S. No	Type of Training institution	Year 2003-04			Year 2008-09		
		Government	Private	Total	Government	Private	Total
1.	State Health and Family Welfare Training Centre	0	0	0	1	0	1
2.	B. Sc. Nursing	1	0	1	1	25	26



	College						
3.	General Nursing Training Centre	2	4	6	4	4	8
4.	M.P.W ( Female )	7	1	8	10	1	11
5.	M.P.W ( Male)	3	0	3	5	2	7

The major problem faced by the state was lack of an adequate state level facility for conducting the state level trainings to prepare the trainers team. Looking at this, a Human Resource Policy was adopted and The SIHFW was conceptualised. Though the SIHFW got constructed and inaugurated with state of the art facilities, lack of training faculty and experts continues to be the major role limiting factor and this has affected the capacity building initiatives at the state level. Many of the training initiatives that were planned in last year could not be initiated in want of this. However, necessary steps are being initiated to overcome these problems.

The training materials needed for multi-skilling medical and paramedical staff got prepared. So far, about 95 doctors each have completed the training on multi-skilling for EmOC and anaesthesia and the course has been further expanded adding other specialities needed for the FRU functions. The material for nationally guided training programmes is also in place. An evaluation of anaesthesia short-term course was conducted by Government of India, which has pointed out a number of shortcomings in the course management- that are being addressed one by one.

For IMNCI training, the state level resource persons are trained under the UNICEF coordinated national level training programme but the next level of trainings could not be initiated except in the case of Rajnandgaon district. The paediatrics faculty from the Raipur medical college also was trained on IMNCI. To monitor the ongoing training activities, technical consultants are being posted at SIHFW.

For Adolescent Health, ARSH training is yet to be initiated. Pilot activity is being initiated in 2 districts on this as well as in ARSH clinics.

On training of ASHA under NRHM, more than 58000 Mitans have completed initial 10<sup>th</sup> rounds of trainings and the training rounds 11, 12, to be started.

At Panchayat level, training on Health & Human Development Index has been revised and further training of Panchayat functionaries and community conducted. A detailed guideline on VHSC functions prepared and the training is ready to be rolled across the state, in year 2008-



09 totals 18322 VHSC formed against and 15326 VHSC A/C opened against the target of 20639, out of that for 14236 funds has been released.

Towards facility development, orientation on assessment of facility performance has been given under Jeevandeep Scheme. The gap on how to formulate facility development plan, how to coordinate with Jeevan Deep Samitis on improving the infrastructure and service quality has slowly been addressed. In the year of 2008-09 out of 894-facility total, 861 Jeevan Deep Samitis formed and money has been released to all the newly formed Jeevan deep Samitis.

ISO certification of Kanker hospital. The Korba District hospital is the first ever in India accredited with ISO certification.

### **19. Operationalisation of FRUs & improving institutional delivery situation:**

With a goal adopted on becoming a site of 24-hour institutional delivery/basic emergency care and skilled birth assistance and manpower planning being implemented, 28 out of a planned 144 PHCs have started to function providing 24 institutional delivery and basic emergency obstetric care. Further, almost all 350 PHCs have become functional as 24-hour sites for Basic emergency obstetric care and for Institutional deliveries.

Still, we realise that the achievements in institutional delivery needs improvement particularly when schemes like Janani Suraksha Yojana are operational. Newly upgraded facilities are yet to reach the desired level of performance on this and more than half of CHCs also have to improve on this. At the PHCs also, though we have succeeded them to initiate institutional deliveries, there is a major need of improving their achievement levels. As far as Sub-Centres are concerned, at present only one fourth( DLHS ) of them have adequate space for institutional delivery and even in these achieving institutional delivery has been difficult due to inability to make referral arrangements. One of the major achievements, job description of ANM has been prepared for the level of Sub Centre and PHC, draft has been sending for final approval. This year we are planning to achieve this by adopting one ANM per panchayat strategy: being the state have almost 2 times of panchayats in number, if compared to Sub centres.

The long-term goal regarding CHCs is to reach IPHS standards – incorporating both the concept of FRU and CEmONC centres and the multiskilled doctors trained in Emergency Obstetric Care and anaesthesia will be post in this facilities. The refresher training will arrange soon.

**Table 1.14: Status of multi-skill training**



Batch	Pt JNM Medical College, Raipur		Chhattisgarh Institute of Medical Sciences, Bilaspur		JLN Hospital and Research Centre, Bhilai		Total No. Trained		Grand Total
	EmOC	LSAS	EmOC	LSAS	EmOC	LSAS	EmOC	LSAS	
Phase I Batch I	4	5	5	5	4	5	13	15	28
Phase II Batch II	2	6	6	3	4	4	12	13	25
Total	6	11	11	8	8	9	25	28	53
Phase II Batch I	2	3	6	3	4	3	12	9	21
Phase II Batch II	1	4	3	5	5	3	9	11	20
Total	3	7	9	8	9	6	21	20	41
Grand Total	9	18	20	16	17	15	46	49	95

The evaluation conducted by Government of India has recommended a number of measures to improve the multi-skill training in Anaesthesia. From this year, the EmOC training shall be held by FOGSI in designated training institutes. The MOU has been signed and the instalment has been already transferred to GOGSI.

## 20. Medically Underserved Areas:

A package for medically underserved areas with special incentives and promotional support for doctors is drafted and a pilot proposal on this is this is submitted for approval as part of this PIP. This comprises a block headquarter based health department colony, transport facilities to peripheries, insurance schemes and family support for education etc. In addition to this, a special strategy for areas in conflict situation is also envisaged, as many areas within Dantewada and similar districts are facing such a situation. Filling medical officer gaps by placing Ayurvedic doctors has been adopted as a strategy in these areas and a special training package is being developed for these doctors so that they can handle almost all those cases that an MBBS doctor can manage at the PHC level (Total no of Ayurvedic doctor in PHC level). An additional compensation package is being approved for these doctors

Another major intervention, for the difficult area to post **Rural Medical Corps**- this envisages a number of initiatives to the doctors and other health staff a number of benefits over and above the salary, including a health worker's colony, insurance support and study support for kin. Similarly, more staff nurse positions on contract in order to operationalise the 24 x 7 PHCs



and CHCs with focus to difficult areas total no of 3-year medical diploma holder will be post in this areas)

## 21. Behaviour Change Communication:

A well-planned IEC/BCC strategy and implementation framework is in place and District Level IEC plans have been made. This year our focus was to make programmes based on this. The basic constraint here was to reinforce the need to understand the importance of IEC/BCC planning for locale specific and outcome based BCC programmes. The state lacks a rigorous planning unit that conceptualises and strategizes the programmes and an implementing team that realises these programmes to the expected levels. We are planning for adding this as part of this PIP.

Currently, the key strategy adopted by the state is folk art based on Kalajathas, wall writings, printed posters and handouts, TV/Radio interventions etc- In HIV-AIDS control, some innovative strategies were adopted. It has been found that the current state level centralisation of this needs to be shifted to local level strategies, for which a policy has been formulated. This year, we are also planning to have specific focus on IEC areas for each month. Four regional workshops carried out to assess the needs of districts for IEC activates.

A BCC kit was developed for the Mitanins during the current year, which is shall act as an interventional tool for raising the right demands at right platforms as well as to improve community roles in health.

## 22. Community Level Care: The Mitanin Programme:

The Mitanin Programme continues to give very good demand side inputs for health services. In this year total **46149** Mitanin has been trained in for Neonatal and child survival for 5 days (10<sup>th</sup> round training), **59489** Mitanin trained for 3 days training.

**Table 1.15: Mitanins and their training status**

District	Trained Mitanins	Essential Neonatal Care given on First Day	Essential intervention for prevention/cure of common Childhood diseases	Support during immunization day	Percentage of active mitanins
Dantewada	3414	2630	2695	2499	76.4
Bastar	5167	4760	4954	4562	92.1
Kanker	2776	2397	2520	2398	87.8
Dhamtari	1627	1354	1439	1492	87.8
Mahasamund	2007	1883	1995	1995	97.5
Raipur	6691	5705	6207	5928	88.9
Durg	5062	4240	4586	4671	88.9
Rajnandgaon	3740	2215	3223	2848	73.9



				1351	83.1
Kawardha	1633	1274	1447	2327	78.1
Bilaspur	4204	3804	3721	3163	85.3
Janjgir/ Champa	3586	2629	3381		
Korba	2274	750	2267	1980	73.2
Raigarh	3731	3277	3270	3307	88.0
Jashpur	3185	2361	2920	2305	79.4
Sarguja	8259	4978	6839	5730	70.8
Koriya	2133	1892	2090	2030	94.0
Total	59489	46149	53554	48586	83.1

Key weakness under the programme is continuing to be the weaker referral response at the health facilities. This is being addressed through an intervention called Mitadin Helpdesk. Currently all the 136 CHC, and district hospital have Mitadin help desk to provide support and to facilitate CSY. (Total no of Mitadin help desk). Lesser technical understanding at the Mitadin level was another problem, which is improving after the rigorous training under Neonatal and Child Survival training based on audio-visuals, video and patient reviews, based on IMNCI and HBNC principles. Mitadin - Anganwadi convergence has improved and this has been envisaged to be further improved through the BCC kit intervention, which is common for AWW and Mitadins. The role being played by the Mitadins and the programme team in the SWASTH Panchayat index generation and planning has also been remarkable and they are expected to anchor the social mobilisation initiatives under the Village Health & Sanitation Committee initiatives.

### 23. Provision of Quality Services and Better Management of facilities:

Jeevan Deep Hospital Development Programme, run by the state as improved Rogi Kalyan Samitis, got inbuilt components for assessment and grading of facility performance and quality, annual plans for betterment of the facility using available funds and special grants, Accreditation standards that lead towards a roadmap to IPHS, and Award/Reward schemes. The scheme was launched in 2005-06 and the interventions at district levels are showing good trends and block level interventions were initiated very recently. At the district level, 3 of the hospitals were accredited as Jeevandeep Golden Star Hospital and 2 of them were accredited as Bronze star hospitals.( Korba hospital ISO Certification ) We could organise a national level award giving ceremony for this in order to boost the motivation of good performers. The district level quality assessment that was taken place as part of the Jeevan Deep Scheme was an eye opener for many of the hospitals and it gave them an insight of how to look at solutions side for many of the critical gaps. With this scheme and other inputs through various programmes, the facility level outputs are expected to be improved. Currently we are getting ready for second year evaluation of district hospitals and moving towards the completion of the first year evaluation of CHCs.



## **24. Baal Hruday Suraksha Yojana:**

With a great success of the scheme, last year of 2009-10 total 1146 application were received out of which 1140 application was referred to respective hospitals. The details are mentioned in the below table.

## **25. PRI Involvement in Health:**

In 2005-06, a specific programme to improve panchayat role in health was initiated by the state under RCH/NRHM called the Swasth Panchayat Scheme. This derived an indicator based status presentation of each and every panchayat on health using a unique tool called Panchayat Health & human Development Index followed by planning by Panchayats to overcome the issues identified as part of the indexing. In 2006, this process was initiated in more than 90% of the Panchayats of the state. One more important feature of this initiative is that there is an award for best Panchayats as well as a special focus planned on weaker Panchayats in a block, which has already been operationalised. Another benefit is that the intra-panchayat and inter-Panchayat variations could be assessed as part of this so that each Panchayats can have sufficient insights on various health issues in terms of improving them. The programme has now entered into rigorous planning phase in all Panchayats, expecting formulation of actionable village health plan at all panchayat level. The introduction of Village Health & Sanitation Committees this year has strengthened this further- we have achieved almost 100% in formation of the VHSCs- a detailed operational guideline was prepared and disseminated on this, which is widely appreciated. Our focus is to orient the VHSCs through a massive campaign and to ensure micro health planning, which is going to materialise very soon. In 2007-08, we have completed the second round of massive data collection on hamlet based HHDI and better performing Panchayats on Health in 132 out of 146 has been identified and awarded. The weaker Panchayats in all these blocks were identified as well. Overall, the programme has touched 9300-gram panchayats HHDI assessment. Prior to this, a major mobilisation campaign was conducted to orient the panchayat heads and a hand book on health related development programmes in the form of panchayat diary was provided to them with Unicef support. Around 20000 PRI functionaries were sensitised under this. Panchayat Health Planning was initiated in about 1000 Panchayats so far and more than 300 plans have been finalised from them. Many of the panchayats are allocating their own resources for health amenities and interventions, is a very good indicator of impact of this initiative. Still, we note that the data quality in HHDI survey was not upto mark in some of the HHDI parameters- we are attributing this to lack of proper orientation due to the massive character of this community based data collection.

## **26. Urban health systems:**



The state has four major cities with more than a lakh population amongst which, Raipur, Durg, Bilaspur and Korba are the highly populated and growing. The growth of these cities is tremendous after Chhattisgarh has become a state. Migration to these cities from village sides is high, and development of these cities is leaving behind a large number of new health challenges to be handled. The populations here are largely served by private providers. The growth of urban slums is the most challenging feature in terms of health services provision where affordability levels are very low and public systems are must. The strategies planned to address this were to set up urban health centres per thousand populations for the poor population particularly living in the slums, peer education programme for the urban vulnerable and community health workers per thousand populations. The implementation of these strategies is at the very early stage and this needs to be strengthened.

Last year, 2 of the districts have completed the urban mapping and in one district, selection of Mitans for the slum areas is complete in Durg district. Lack of proper guidelines and operational manuals, the districts are facing some problem in taking this programme forward. Lack of proper health systems in these areas and improper coordination with urban local bodies are some of the other limiting factors. However, this year we are going to focus on this system related issues. The introduction of Urban Health Mission shall further enhance this. One of the prime agenda for SHRC in the coming year will be to scale up the urban community interventions for health.



## 27. Technical Assistance:

The State Health Resource Centre (SHRC) is the key agency to provide technical assistance in the state, which plays a key role in design, planning and functional support to the state health mission and society, other than UNICEF. The Regional Resource Centre for RCH, the Micronutrient Initiative and CINI, CARE are also providing some assistance in select areas where their programmes are concerned. Another technical support envisaged was for the EU partnership but this has not yet been materialised. In addition, in the area of training and BCC, the SIHFW is being built up and this is not fully functional as the faculty appointment is not complete yet.

The key technical inputs to the NRHM come from the State Health Resource Centre. An autonomous body especially set up for health sector reforms in the state, the SHRC got a team of experts in almost all walks of Public Health. They give implementation support too, for all the community based health programmes like the Mitnin Programme, the Swasth Panchayat initiatives, Village Health & Sanitation Committee operationalisation, The Jeevan Deep Hospital Reforms programme etc. They do play coordinating role in the capacity building initiatives like the multiskilling training of medical officers for FRU operationalisation, professionalization of health management through PHRN fast-track training programme etc. SHRC act as the coordinating unit for design & planning of NRHM initiatives, supported by other technical agencies. Apart from NRHM planning, it plays critical role in the ongoing European Union State Partnership Programme as well. The convergence initiatives with Department of Panchayat, Education, ICDS etc are also been coordinated by SHRC. The state government has requested the SHRC to set up an AYUSH technical wing as well, in order to push up the mainstreaming of AYUSH systems. Other than this, the SHRC supports the state in preparation of acts, policies etc related to health like role under their role as additional technical capacity to the health department- like the Health & Population Policy, Revision of Essential Drug List, Clinical Establishments Act, Medical University Act, VHSC Guidelines etc.

Another Technical Assistance agency in the state is UNICEF, with a Major objective of reduction in infant and maternal deaths. Popularization of institutional deliveries to ensure reach at least 60 percent

- Roll out of IMNCI throughout the state to ensure recognition and referral of sick neonates locally supported by Mitnin.
- Facilitate the Creation of sick newborn care units at district hospitals.
- Promotion of Zinc based ORS.
- Strengthen village shealth and nutrition days in order to promote full coverage of Immunization.



### **Major state-specific UNICEF initiatives in Chhattisgarh are:**

- To facilitate JSY help line.
- To put up the bottleneck analysis of the state and capacity building on technique useful for the district health plan.
- Support a child survival cell at SIHFW for capacity building and monitoring support.
- To support the Mitadin programme in IMNCI based training.
- To support IMNCI training programme for Medical Officers.
- A touch screen for health awareness 'Sishu Sanraksak Kiosk' will be provided to district hospitals that have Mitadin help desk.
- To provide technical support on integrated BCC kit plan, Hepatitis B promotion.
- To support the 'Sishu Sanraksaan Maah'
- Neonatal Intensive Care Units (NICUs) will be established in eligible district hospitals.
- To promote and distribute the bed nets to pregnant women of the tribal district.
- Rajnandgaon will continue to be a focus district for UNICEF and support major health initiatives.

### **Technical Assistance from Micronutrient Initiative**

The Micronutrient Initiative-CINI collaboration gives technical support in biannual vitamin-a supplementation to be held as a comprehensive child-protection campaign called Sishu Sanraksaan Maah. They do take up all the activities right from the planning, mobilisation, training and monitoring of this campaign with UNICEF Support.

### **Mainstreaming of AYUSH**

The National Health Policy (1983) visualized an important role for the AYUSH practitioners in the delivery of health services. In order to give focused attention to the development and optimal utilization of this branch of medicine and to ensure that AYUSH practitioners are brought under the regular health system. This intervention is expected to provide complementary system of care along with practitioners of modern systems of medicine. This policy has laid down a set of goals for AYUSH system.

The Government of Chhattisgarh has also given equal status and fairer chance of development of AYUSH to its full potential in providing health care. Mainstreaming AYUSH institutions and practitioners with modern systems of medicine in Chhattisgarh has been major priority, so that people have access to complementary systems of care. Utilizing human resources of AYUSH in the national health programmes, with the ultimate aim of



enhancing the outreach of AYUSH health care in an accessible, acceptable, affordable, and quality manner is visualized. The department of AYUSH has reasserted on mainstreaming component with constant efforts and activities in coordination with modern system of medicine coordination.

### **Status of AYUSH Institutions in Comparison with Allopathic Set up**

The mainstream health provides services at district, block and village level as primary, secondary and tertiary level of services. The AYUSH health care set up in Chhattisgarh is a large cadre of health care institutions at primary and tertiary level. The primary institutions of AYUSH are District Ayurveda Hospitals, which cater OPD, IPD and special health care services under AYUSH. The services at block level are deficient with no utilization of manpower at the block levels to provide services and lack of block level coordination and monitoring.

The department of AYUSH in Chhattisgarh aims at the identification and conservation of rare and extinct herbs. With the motto of testing the herbs for their potency and toxicity, the Department of AYUSH has established a Drug testing and Research laboratory in Government Ayurveda College. So far, 65 drugs are tested for Authenticity.

**Table 1.18: comparative AYUSH vs. Allopathic service deliver facilities**

<b>Allopathic Health Care Delivery facilities</b>	<b>Numbers</b>	<b>AYUSH Facilities</b>	<b>Numbers</b>
Medical college hospitals	3	Ayurveda college hospitals	1
District Hospitals	17	District Ayurveda Hospitals	6
CHC	143	Health facility at block level	0
PHC	716	AYUSH Dispensaries	692(Total)
Sub Centre	4776	Ayurveda Dispensaries	634
		Homeopathy Dispensaries	52
		Unani Dispensaries	6
Drug testing and Research Centre	0	Drug testing and Research Centre	1
Pharmacy	0	Ayurvedic pharmacy	1



The educational institutions under AYUSH in Chhattisgarh are not sufficient to provide AYUSH education to young aspirants. The AYUSH institutions in Chhattisgarh need to be increased, So that the State can produce quality professionals to serve in AYUSH health services in Chhattisgarh. The Allopathic institutions in the state are three and these are established in Bilaspur, Raipur and Jagadalpur. The AYUSH educational institutions in Chhattisgarh are one Ayurveda college in Raipur with the capacity of 55 students and there is deficiency of Homeopathy, Unani, Naturopathy and Yoga Government educational institutions in Chhattisgarh.

### **AYUSH Interventions under mainstreaming in Chhattisgarh:**

#### **Establishment**

- 15 AYUSH wings in District Hospitals,
- 22 Specialized therapy centre in CHC
- 24 AYUSH specialty clinics in PHC
- 357 AYUSH OPD in PHC & 42 AYUSH OPD in CHC



**Table 1.21: Present status of AYUSH wings, specialized therapy centre and speciality clinic**

Districts	AYUSH Wings	Functional	Gaps	Specialized Therapy Centres/ Speciality Clinics	Functional	Gaps
Kawardha	1	0	1	2	0	2
Janjgir Champa	2	2	0	1	-	1
Koriya	1	0	1	2	0	2
Raipur	1	0	1	2	0	2
Surguja	1	0	1	3	0	3
Korba	1	0	1	1	0	1
Raigarh	1	0	1	2	0	2
Dhamtari	1	0	1	4	0	4
Mahasamund	1	0	1	2	0	2
Durg	1	1	0	2	1	1
Kanker	1	0	1	4	0	4
Jashpur	1	0	1	3	0	3
Rajnandgaon	1	1	0	4	0	4
Bastar	-	-	-	2	-	2
Dantewada	1	0	1	6	0	6
Bilaspur	-	-	-	6	0	6
Total	15	4	11	46	1	45

At present out of 15 AYUSH wings, only 4 AYUSH wings (1in Durg, 2 in Janjgir and 1 in Rajnandgaon) are fully operational. Out of 24 specialized therapy centres, only one in Durg is functional and 22 special clinics established nothing is functional. The major constraint faced is of less or no space allocation in Allopathic centres.

#### **Co-location of 85 AYUSH dispensaries in PHC\CHC after launching of NRHM**

As a primary initiative, 85 centres are collocated in PHC\CHC and in rest 613 centres AYUSH facilities are planned to be co-located in a systematic manner. Mainstreaming activities in Chhattisgarh have been initiated from the year 2007. Collocation of AYUSH dispensaries in PHC or CHC building has been undertaken in a planned manner. 85 such dispensaries were selected which were placed near PHC\CHC and efforts were taken for collocation. Where AYUSH dispensaries were in a good status with best infrastructure the PHC's were collocated in AYUSH Dispensaries. Eight dispensaries (Khatti, Pantora, Urba, Nagpur bazaar, Karpavand, Bainur, Gangalur and Faraspal) were identified in total 85 which had good infrastructure were PHC was merged.



**Table 1.22: Present Status of Co-located Centres:**

Districts	Co-located centres in CHC	Co-located centres in PHC	Co-located centres in Ayush Dispensaries	Fully Functional	Doctors in place	Compounders in place	Dispensary attendants in place
Raipur	0	7	0	7	6	3	6
Mahasamund	0	2	1	2	1	3	2
Korba	1	4	0	3	4	4	5
Dhamtari	0	3	0	3	0	1	1
Bilaspur	5	7	0	3	12	10	8
Janjgir Champa	1	3	1	3	5	4	4
Rajnandgaon	0	3	0	1	1	3	2
Kawardha	0	1	0	1	1	1	0
Raigarh	0	3	1	3	4	2	4
Jashpur	0	1	0	1	1	1	1
Surguja	1	22	0	6	23	20	22
Koriya	0	5	1	2	5	6	6
Dantewada	2	0	2	3	4	2	3
Durg	1	10	0	7	11	6	5
Bastar	0	0	2	2	2	2	2

### Availability of Medicines in Co-Located Centres

Under NRHM the provision of essential medicine for the collocated centres as Rs 25000/- is provided to the collocated centres. The other required medicines are fulfilled by the department of AYUSH as per the demands placed by the Ayurveda medical officers annually.

### Constraints Faced:

- Space allocated is not sufficient to the standards for collocation in the PHC\CHC.
- No space provision for collocation of AYUSH dispensaries in the PHC\CHC as the existing space in the PHC is less.
- No proper space allocation for CSIDC (nodal agency for construction of AYUSH centres in mainstream health).CSIDC has agreed for new



construction of AYUSH dispensary in the PHC, which is attached to existing building.

- Minimum space requirement for development of Ayush wing, speciality centres and speciality clinic as per the central government guideline as charted out is deficient in PHC and CHC for starting the AYUSH units in allopathic wings.

### **Support of AYUSH Medical officers in National Health Programmes**

The major input of AYUSH physicians in National Health programmes in Chhattisgarh helps in implementation of National programmes. The AYUSH physician provides continuous support to all the programmes run by the Government - encouraging mothers to immunize their child, formation of malaria slides, counselling and encouraging the couples for family planning. A target is set for achievement in family planning. Supporting all the other programmes and active participation of AYUSH physicians is present in Chhattisgarh from the day of its inception and the activities have been strengthened from the NRHM period by capacity building of AYUSH physicians in national programmes.

### **Capacity building as a part of mainstreaming**

#### **Training of AYUSH physicians:**

- The training of Integration of AYUSH physicians in Mainstream Health is initiated, till now 60 AYUSH physicians have been trained. Another TOT training under NRHM has been undertaken for Mainstreaming AYUSH in Delhi 3 physicians have been trained under this programme.
- Essential maternal Health and Child survival : As further expansion of service delivery of AYUSH physicians in national programmes a training programme of AYUSH physicians has been designed for 2008-09 Maternal and Child health considering the high Maternal and infant mortality in Chhattisgarh. To monitor this effectively, the AYUSH directorate and Directorate of Health services are keeping track of this and monitoring report is brought out regularly. The targets set are all the Medical officers of Dispensaries and District Ayurveda medical officers.

#### **Training of Mitanin for AYUSH Mainstreaming:**

**Training of 60,000 Mitanin on AYUSH module “Jadi buti lae kar lae illaj” as a means of propagation and utilization of Herbal combinations for common ailments by Mitanins.**



## A RCH – (RCH Flexible Pool)

### A.1 MATERNAL HEALTH: Operationalise facilities (only dissemination, monitoring, and quality)

#### A.1.1 Operationalise facilities (Only dissemination, monitoring and quality)

##### A.1.1.1 Operationalise FRUs

##### A.1.1.1.1 Blood Storage Facility:

Most of the maternal deaths occur due to haemorrhage during labour or in post partum period. To provide comprehensive obstetric care, prevent complications due to haemorrhage, promote caesarean section in First Referral Unit, it is mandatory to have blood transfusion facility. At present, we have a fund allocation of Rs. 485 lakh @Rs. 5 lakh per unit, for 97 CHCs / FRUs. The money was released to Directorate of Health Services and District Health Societies earlier. However, at present, we have 56 FRUs which has to be operationalised including District Hospitals. Of these, after re-location of doctors in FRUs, 20 CHC FRUs can be made functional with opening of blood storage units. Currently, 7 district hospitals do not have blood bank facility, of which we can start blood storage units in 3 districts, namely, Jashpur, Narayanpur and Bijapur. In the year 2010-11 remaining 18 CHC FRUs would be operationalised with establishment of Blood Storage Unit.

#### Budget

The budget for the proposed activity will come from re-appropriation of previous budgets which had been allocated to DHS and District Health Societies for development of blood storage units. Therefore, no fund is required from NRHM.

The inspection, Licensing and Training component for Blood Storage Unit will be coordinate with CGSACS along with SHRC Technical support.

##### A.1.1.1.2 Indemnity Insurance for the Multi Skilled MOs

To conduct caesarean section, the multi-skilled MOs need some financial protection against untoward incidents. An insurance coverage for 78 doctors had been issued last year. This year it is proposed to insure the 78 doctors of previous year and an additional 48 new EmOC trained and 30 new LSAS trained MOs @ Rs. 5000 will be required for 2010-11.



**Table: Budget estimation for indemnity insurance**

S.N.	Unit Description	Unit Cost	No. of Units	Duration	Total Cost (lakh)
1	Indemnity Insurance for EmOC trained doctors	5000	77	1	3.85
2.	LSAS trained doctors	5000	73	1	3.65
Total					7.50

#### **A.1.1.2 Operationalise 24x7 PHCs**

Rs. 7,011,2000 was allocated last year for 1152 Staff Nurse appointment on contract basis in year 2009-10. Out of which 213 nurses have been appointed. Now the strategy for 2010-11 another 150 Staff Nurses can be appointed with monthly salary of Rs. 9000.

Table:

Year	No.	Monthly salary	Duration (months)	Total cost (lakh)
2010-11	150	9000	6	81.00
2010-11	213	9000	12	230.04
Total cost				311.04

#### **A.1.1.3 MTP services at health facilities**

Efforts are being made to provide the unmet need of safe abortion services, to avoid abortion in the unauthorized health facility and so that sepsis and other complications are minimized and to improve utilization of existing facilities. To further expand the MTP facilities for safe abortion service has been made accessible to all women in the state including women in rural area.

#### **A.1.1.4 RTI/STI services at health facilities**

Management of STI infections is a significant component of the National AIDS Control Programme. Training of trainers for the participants identified as State supervisory team from 3 medical colleges has been conducted. Training of Medical officers, staff nurses and lab technicians will be held in collaboration with.



### A.1.2 Referral Transport Linkages

There is a provision of financial support under JSY for self-referral and transportation from home to Sub Centre/ PHC/CHC. Nevertheless, some of the cases are referred to higher centre, as it cannot be managed at those centres. Most of the time the funds available under JSY get exhausted at the time of first referral and no funds are available for subsequent referral to higher centres which is usually quite far and the pregnant mother and their relatives have to manage from their own source.

The vehicles for transportation of patient are either not available during emergency or even when available are too expensive for the poor families

To promote rapid referral in times of emergency, mapping of the resources in every village, sub centre, PHC, CHC and hospital in the district, listing ambulances and willing private owners vehicle and phone numbers will be displayed and awareness would be generated through local print and electronic media.. . The birth plan will be entered in the application form during registration of ANC as well as, contact details of the owner of vehicle to use in case of emergencies

Out of the total number of institutional deliveries taking place under JSY, 10% of the deliveries will fall under the category where the expecting mother might be referred to higher centres. For these cases, additional funds will be made available at the PHC and CHC to be utilized for second referral. In year 260000 expected number of JSY cases is around that is 10 % of total are expecting for second referral. To rationalise the reimbursement for beneficiaries, the criteria for reimbursement will be done based on distance between the two referral health facilities and operational guideline to be issued to the district. In an average cost for second referral transport is estimated approximately Rs. 500, its will be varied. In case it is needed, the first referral assistance can be raised from Rs.250 and above as required. For that the amount proposed in second referral may be partially utilized to compensate the need concern medical officer will take decision based on the distance from the residence to the PHC/CHC to compensate the extra amount needed

The fund will be issued to the districts will replenished after the district gives 50% utilization of the fund given in each quarter.

Budget for JSY Second referral support



### Budget Support for JSY Second referral support

JSY institutional Deliveries expected in 2010-11	JSY institutional Deliveries (Rural) required second referral	Rs @Rs.500 for second referral (in lakhs)
260000	5000	25.00

#### A.1.3 Integrated outreach RCH services / Camps

Due to paucity of skilled Medical Officers at PHC level, a large rural population is deprived of proper diagnostic and curative services. In such situation RCH camps is useful for screening and diagnostic purposes. It is proposed to organise one RCH outreach camp on fixed days in all 715 PHCs. The fixed roster of camps at PHC will be publicised and communicated to the rural people 2 – 3 days before organisation of camps through mike, poster etc. The expected unit cost for IEC activity will be Rs. 1000 per camp. Additional camp expenditure may be incurred from the JDS of the respective PHC.

Table

No. of PHCs	No. of Camps to be held	Unit Cost	Total Cost (lakhs)
715	1 camp per PHC	Rs. 1000	7.15

#### A.1.3.1 Monthly Village Health and Nutrition Days

As VHND is an important platform to observe comprehensive promotive and preventive health care. VHND is being organized with collaboration with AWW, VHSC member (PRI) in a village at AWW centre or Sub centre, subject to availability of building infrastructure.

A comprehensive monitoring format has been developed and circulated to district and block level officials. It will ensure quality and access of the health care specifically ANC, PNC, Immunization and preparation of slides of fever case and chronic cough for Malaria and T.B respectively. If any malnourished children will be detected at VHND would be referred to nearest health facilities. In a maternal and child register included a planned and observed session reporting of VHND in a monthly basis.

The incentive payment to Mitnin for various scheme to be carried out in VHND itself and entered in a Mitnin passbook, which state has planned after the recommendation of CRM team. For the remote and hard to reach areas mobile unit will be utilize to conduct VHND.



#### A.1.4 Janani Suraksha Yojana / JSY

The Janani Suraksha Yojana implies safe motherhood and healthy child by ensuring every delivery as supervised institutional delivery. There is remarkable improvement in the total institutional deliveries in the state, still high rates of maternal mortality is the major public health problem in Chhattisgarh. The statistics shows that the maternal mortality ratio of 379 per 100,000 live births (SRS 2005) in Chhattisgarh compared to 110 in National reveal the true contrast and seriousness of the problem.

State had developed an operational guideline in view of local health infrastructure and geographical situation as per GOI norms. It improves:-

1. Timely reporting
2. Time lag of payment to beneficiaries and Mitnin
3. Institutional wise monitoring
4. Expedite financial transaction and reporting

Re appropriation of Specialist, PGMOs, EmOC and LSAS trained doctors was carried out according to vacancy in FRUs and selected CHCs to operationalize them.

#### Comparative performance of Chhattisgarh in RCH indicators

S. No.	Indicators	Chhattisgarh	National	Source of data
1	Maternal Mortality Rate (per 100,000 live births)	335	254	SRS 2004 – 06
2	Infant Mortality Rate (per 1000 live births)	57	53	SRS Report – Oct, 2008

#### Progress so far:

Following data show the improvement trend of JSY in Chhattisgarh, if we compare last five year's data. Although we have achieved only 38 % institutional delivery in year 2009-2010, yet we need to revise and improve our strategies to improve the coverage.



**Table: Trend in number of Institutional deliveries**

S. No.	Years	Total Deliveries	Home Deliveries	Institutional Deliveries	% of Institutional Deliveries
1	2005-06	568781	465970	102811	18%
2	2006-07	596247	464913	131334	22%
3	2007-08	563624	414599	149025	26%
4	2008-09	567135	387276	179859	32%
5	2009-10 (up to November 2009)	374104	232077	142027	38%

**Progress of Institutional deliveries**

(As per NFHS -2, NFHS -3)

	Chhattisgarh	India				
	NFHS-2(98-99)	NFHS-3(06-07)	Change	NFHS-2(98-99)	NFHS-3(06-07)	Change
<b>Institutional Deliveries</b>	<b>15.8</b>	<b>27.2</b>	<b>11.4</b>	<b>11.4</b>	<b>33.6</b>	<b>20.4</b>

Chhattisgarh, the pioneer state to launch India's largest community base Mitanin program, will put sincere efforts to mobilise this resource to motivate the community for institutional deliveries.

The following table shows that involvement of **Mitanins supports for institutional deliveries**. In year 2005- 06 it was 0.09, in year 2006-07 it improved to 4.50 and in 2009-10 the total referral by Mitani is reached 33.83 %



Year	Total Deliveries	Mitanins Services to Beneficiaries			% of Assistance to JSY Beneficiaries by Mitans
		Referral	Escort	Total	
2005-06	568781	222	282	504	0.09
2006-07	596247	10631	16188	26819	4.50
2007-08	563624	31298	49229	80527	14.29
2008-09	567135	34297	82448	116745	20.59
2009-10 (up to November 2010)	374104	61371	65197	126568	33.83

#### Progress of JSY Beneficiaries

Year	Total Deliveries	JSY			
		Home Deliveries	Institutional Deliveries	Total Deliveries	% of JSY beneficiaries
2005-06	568781	1659	511	2170	0.38
2006-07	596247	44642	30814	75456	12.66
2007-08	563624	74229	101749	175978	31.22
2008-09	567135	90764	134848	225612	39.78
2009-10 (up to November 2010)	374104	116000	53098	169098	45.20



### **Strategy for the year 2010-11**

The Janani Suraksha Yojana intend to ensure safe motherhood and healthy child by promoting every pregnant mother should go for institutional delivery under the supervision of qualified health personnel e.g. Gynaecologist, EmOC trained medical officer, Staff nurse, LHV, ANM or SBA.

For the year 2010-11 we have set target of at least 70% institutional deliveries out of total expected deliveries. More than 60% Deliveries among the BPL families should be institutional. 48 hours Post delivery stays in all District hospitals, community health centre and accredited private hospitals and most of health facilities especially identified PHC for institutional deliveries. At SHC centre delivery to ensure follow up within 48 hours by ANM.

We have a JSY application and referral-cum voucher form in place. We also developed a village wise jachha-Bachha (Mother and Child Register) for line listing of individual beneficiaries, monitoring and follow up of both mother and baby.

With micro planning of every pregnancy from day of registration to birth of child till the postpartum and complete immunization. Our state would achieve the national goal of IMR and MMR by 2012.

### **In the coming year more emphasis will be given to**

1. Early registration of pregnancy
2. Individual pregnancy tracking system
3. Micro -birth planning
4. Capacity building of ANM, SBA, Mitnin
5. Ensure transport of pregnant mother to nearest health facility
6. Providing basic obstetric care, EmOC and safe MTP services by Strengthening of health facility and PPP model, Accreditation of Private hospitals.
7. Post- partum follow up and care
8. Post-partum counselling for family planning.
9. IEC activity for community awareness.
10. Monitoring and Evaluation
11. Establishment of grievance redressal system



## **Interventions:**

### **Application for JSY beneficiaries:**

Aiming the proper documentation and tracking mechanism for monitoring of JSY scheme state had planned which is in place as an innovative scheme for the JSY beneficiaries. All the beneficiaries have to fill an application to avail JSY benefit under the scheme. These printed formats are available with the ANM, AWW, and Panchayat institute and soon with the accredited private facility too. The beneficiaries need to fill the form and send back to the facility where they are availing service for the delivery.

A referral forms are providing along with the application form, by which beneficiaries and Mitandin can be reimburse the benefit after producing to the respective facility in case Public Institution, while accredited facility in case of private facility. The time lines to encash this coupon will be three month from the day of delivery conducted, in case the time line over, the cash coupon (Referral Form) will automatically cancelled. Mitandin will only reimburse the cash, if she stayed in hospital. In any case, any member from Mitandin family accompany to beneficiaries to refer in Public Hospital or accredited private facility, Mitandin will be eligible for promotional benefits.

A team level approach with the help of ANM, AWW and Mitandin and Trained Dais to contact families and pregnant women is the main strategy in this year. More emphasis will be given to provide antenatal check-up (8/8) throughout the pregnancy.

### **Accreditation of private Facilities:**

The private sector accounts for a substantial proportion of healthcare in India (50 per cent of inpatient care and 60-70 per cent of outpatient care) and so has plays a crucial role in Indian healthcare system. Consequently, the private healthcare delivery system in India has remained largely fragmented and uncontrolled, Even in Chhattisgarh it is not different from the national picture. In the recent years, Chhattisgarh has come up with many models to collaborate with Private health care to widening the pan of health care service and provide health care vicinity where community can access when they needed. Taking forward this innovation, Government has planned to accredited private health facility for JSY Scheme under the NRHM.

In this scheme, the private facility will be identified according to availability of level of basic emergency obstetric care and comprehensive care. Selection will be done on the basics of certain decided criteria's – like for basics obstetric care there should be at least MBBS doctor or BAMS from recognized institute with support of trained Mid wife / Nurse / Staff Nurse along with a availability of basic supportive infrastructure like delivery table, basic



emergency equipments, facility for new born resuscitation and proper referral service in case of any complication. Similarly, for comprehensive obstetric care there should be a facility of LSCS (Caesarean section), Gynaecologist, paediatrician and Anaesthetist (full time/ on call basis) along with facility for blood transfusion, laboratory service, basic emergency drug, facility for communication and proper referral in case of emergency.

For the better functioning on the scheme and documentation of the cases , for each case Rs. 100 will be paid to respective accredited facility for documentation and reporting after submission of proper document to respective BMO/CMHO. 153 private hospitals are accredited so far in the state .No separate budget has been proposed for this activity. The requirement will be met through the administrative cost of JSY.

During 2009-10 deliveries reported by private institutions is 4.3%.

#### **Budget for JSY support for pregnant women**

Unit	Unit cost	No. of units	Duration	Total (lakh)
Support for home delivery	500	60000	1 year	300.00
Support for institutional delivery(urban)	1200	140000	1 year	1680.00
Support for institutional delivery(Rural)	2000	260000	1 year	5200.00
<b>Total</b>		<b>460000</b>	<b>1 year</b>	<b>7180.00</b>
4 % of total requirement for JSY administrative/IEC and cost				287.20
<b>Total including 4 % of total requirement for JSY administrative/IEC and cost</b>				<b>7467.20</b>

#### **A.1.4.1 Incentivisation for institutional delivery**

**Incentivisation:** To motivate the staff from sub canters to FRU level incentive on the above performance from the set bench mark for their institution. In this context annual based incentive will be given the facility. Considering the demographic profile of the state facilities will be divided in rural and urban areas.



**Budget and Bench mark for Incentivisation**

Budget and Bench mark for Incentivisation								
Name of institution	Location	No. of Institution	Proposed Benchmark		Annual	Estimated Case no. for incentives	Unit Cost	Total Cost (F*G*H*)
			Minimum Performance	approx number of Institution will achieve minimum bench Mark				
B	C	D	E	F	G	H	I	
Sub Centre	Rural	4741	40	1000	20	200	40.00	
	Tribal		20		20	200		
PHC	Rural	721	250	75	50	100	3.75	
	Tribal		180		100	100		
Administrative block Head (BMO, BPM & other)	Rural	146	2000	30		15000	21.90	
	Tribal		1500			15000		
District Authority (CMHO & Nodal)			1. 50-60 2. 61-75 3. 76 and above	5 Districts		50000, 35000, 20000	5.00	
SPM Unit			1. 50-60 2. 61-75 3. 76 and above			100000 , 70000, 40000	10.00	
Grand Total								80.65



### A.1.5 JSY Call Centre

With the emerging significance of the Janani Suraksha Yojana, Chhattisgarh has progressively increasing institutional deliveries across the state. In spite of having provision for emergency transport support under JSY, challenges are there to arrange transportation in the emergencies. To address these issue, many interventions has been taken to overcome the situation, but evidence are showing that free transportation services on call basis will be positive impart to increase the referral cases. Considering all these possibilities and opportunities, state has decided to start round the clock call centre in a Raipur to facilitate emergency transport and consultancy facility for the periphery doctors and other staff.

Since every Community Health Centre is having at least one functional ambulance and total 300 ambulances in the state, will be used for JSY emergencies. A dynamic call forwarder system will be established with four operators will be established. The whole operations will be carried out on the PPP based model. All the ambulance drivers will be provide mobile cell and monthly recharge to uninterrupted communication and tracking mechanism will establish for ambulances and to manage fake calls. Taking one step ahead, 102 model (Ambulance service) and 104 models (Medical help) will be start with coordination with this call centre. Emergencies and expected to deal with such situations, panel will be form with the specialist doctors to consult any medical emergency in field or for guidance to periphery doctors and staff if they needed. In which 10 doctors will be empanelled on the fixed consultancy of Rs. 10000 per month.

#### The estimated budget for the call centre

S. No.	Particular	No. Of Unit	Unit Cost	Total (in lakhs)
	Tele phone and Equipment	-	200000	2.00
	Appointment of telephone operator	16	6000	11.52
	Appointment of Supervisor	01	15000	1.80
	Cost of mobile phone	300	2000	6.00
	Cost of recharge for close circuit group	300	350	12.60
	Remuneration for consultant doctors	10	10000	12.00
	Total			45.92



### **A.1.6 Maternal and infant death auditing committee:**

For Maternal and Infant Death auditing, Auditing Committees has been formed at State and District level and is functional. The committee members at the state include the JSY Nodal (State), The State Immunization Nodal Officer & the Maternal Health Nodal officer and their assistants. At the district level, the committee is formed under chairmanship of CMHO and members consist of JSY Nodal Officer, the DIO, the RCH Nodal Officer, DPM-NRHM and their assistants. An orientation workshop was conducted where formats & guidelines regarding maternal death audit were circulated.

The main components for auditing are the following:

1. ANC registration
2. ANC Check up
3. Delivery auditing ( Enquire about care received during deliveries)
4. Post partum care, complication
5. BCG Vaccination
6. Probable cause of maternal and infant death

The review mechanism at the district level is done quarterly to resolve the problem at hand. The budget for the auditing process and for the quarterly meeting at the districts could be as follows:

Rs. 200 per head (Logistic support and refreshment). Total Number of Participants expected for the meeting consisting of all the stakeholders is 50 at the state as well district. At the state level, total 4 meeting will conduct and similarly 72 meetings in eighteen districts. Therefore, cost of meeting expenses for all this meetings will be **Rs.7.6** lakh only.

Meeting at State Level = 40000

Meetings at District level= 720,000



## A.2 Child Health

Status of IMR		SRS 2000	SRS 2008
State IMR	Total	79 per 1000 live birth	57 per 1000 live birth
	Rural	95 per 1000 live birth	59 per 1000 live births
	Urban	49 per 1000 live birth	48 per 1000 live births
Current average rate of reduction		2.75 per year	
Goal : Overall (2012)		30 per 1000 live births	
Goal : Annual reduction required from 2008 to 2012		6.75 per year	
Status of Neonatal Mortality Rate		75 % of infant deaths is during neonatal period (SRS)	

Indicators	NFHS 2 (1998 - 99)	NFHS 3 (2005)	DLHS 2 (2002 - 04)	DLHS 3 (2007 - 08)	State target for 2012
Institutional deliveries	13.8%	15.7%	18.1%	18.1%	75.0%
Children under 3 years breastfed within one hour of birth		24.5%	29.5%	50.1%	80.0%
Children age 0 – 5 months exclusively breastfed		82.0%		78.3%	95.0%
Children age 6 – 9 months receiving solid/semisolid and breast milk		54.5%		56.8%	80.0%
Children with Diarrhoea in the last 2 weeks who received ORS	29.7%	42.0%	41.7%	36.6%	100.0%
Children with Diarrhoea in the last 2 weeks who were given treatment	65.3%	59.3%	69.3%	67.0%	100.0%
Children with ARI in the last 2 weeks who was taken to a health facility		69.5%	63.3%	68.1%	100.0%



Children with ARI in the last 2 weeks who received antibiotics		1.0%			100.0%
Children age 6 to 35 months who are anaemia	88.0%	81.0%			25.0%
Children who received at least one dose of Vitamin A		12.7%	32.4%	65.1%	95.0%
Children below 3 years who are underweight	60.80%	52.10%			40.0%
Prevalence of diarrhoea ARI in Chhattisgarh: 4.4% of under 5 year population per year (NFHS 3)					
Prevalence of diarrhoea in Chhattisgarh: 1.84 i.e. approx 2 episodes per child per year					

### Objectives:

1. Reduction of infant mortality rate from the current 57 per 1000 live births (SRS 2008) to less than 30 by the year 2012.
2. Reduction of under five child mortality rate from the current 81 per 1000 live births (estimation as per SRS 2005) to less than 40 by the year 2012.
3. Reduction of child anaemia levels from the current 81% (NFHS III) to 25% by the year 2012.
4. At least 80% under five year old children sleep under an insecticide treated bed net.

### Strategies:

1. At least 80% of newborns will be started on breastfeed within one hour of birth.
2. At least 80% newborns will be assessed by an IMNCI trained personnel to access for danger signs and ensure prompt referral where indicated.
3. Reduce neonatal deaths in referral units by making Special New Born Care Unit operational in twelve district level hospitals.
4. 100% measles vaccination coverage by strengthening sub centre level services and its supervision. (This would be addressed in immunization PIP)
5. At least 80% children eligible receive appropriate dose of Vitamin A and deworming through a bi-annual approach.
6. Ensure institutional care to treat severe acute malnutrition cases



7. *At least 75% diarrhoea cases receive appropriate treatment through ORS and Zinc therapy.*
8. *Ensure bi-annual systematic impregnation of bed nets.*
9. *Ensure effective implementation and monitoring of child health services provision by establishing Maternal and Child Survival Cell.*
10. *Ensure community awareness on critical child health issues through planned BCC interventions.*
11. *Ensure better penetration and impact of health services, in school-going children.*
12. *Addressing disparities in child health services outreach services, through special strategies for difficult areas, urban and tribal areas.*
13. *Training to fill skill gaps in each of these areas*

### **Activities:**

*In order to achieve the above objectives the state will undertake a two prong approach:*

#### **1. Community and home based approach**

#### **2. Health Facility based approach**

*Under the Community based approach, the Navajat Swagath Bheit through practise of IMNCI by Mitans will raise awareness on newborn care and empower families as well as communities to take timely, appropriate action when things go wrong during neonatal period preventing many neonatal deaths. Similarly, the Sishu Sanrakshaan Maah twice a year will improve the access of RCH services to deprived communities in remote rural areas enhancing child survival.*

*The Health Facility based approach through operationalising Newborn Corners, Stabilization Units, Special Newborn Care Units, accreditation of health institutions based on child friendly practices like promotion of breast feeding, immunisation and correct case management of Severe Acute Malnutrition, providing essential care to all newborns in 24x 7 hour PHCs will complement the demand generation created through the community based approach.*

*The Health Facility based approach will focus on ensuring quality standards in all government facilities so that clients reaching these health institutions are not let down. To ensure this a **State Task Force for Child Friendly Health Facility** is already set up in Chhattisgarh in 2009 - 10. This Task Force comprise of officials from **Department of Health and Family Welfare, UNICEF, IAP and BPNI** etc will be constituted every year an **Accreditation Committee** of renowned professionals to visit, assess and certify the "Child Friendly" status of that Health Facility based on erstwhile BFHI assessment criteria using standard assessment tools and formats.*



### **A.2.1 IMNCI: Integrated Management of Neonatal and Childhood Illnesses**

75 percent of infant deaths occur in neonates in Chhattisgarh (SRS 2007). Now, as institutional deliveries are increasing due to Janani Suraksha Yojana, we have increasing newborns who are taking birth in health institutions. Till now, all 62,000 Mitanins (AHSA) are trained in IMNCI through the support from NRHM and UNICEF. Training of Medical Officers in IMNCI has been initiated by SIHFW through the RCH Capacity Building Unit, which is established with support from UNICEF. This year, the GOI approved IMNCI package of eight days training will be used for training all ANMs of PHCs, CHCs and District Hospitals – which will be coordinated through the RCH Capacity Building Unit of SIHFW. These training will be organised in close collaboration with 1) Pt. J N M Medical College, Raipur, 2) Bastar Medical College and 3) Bilaspur Medical College.

This year the IMNCI programme activities will be launch across the state for health workers and the major activities will be training of them.

**The Budget for IMNCI will be available from Department of Women and Child development and State budget.**

### **A.2.2 Facility Based Newborn Care/FBNC**

The state with collaboration with UNICEF and NNF has already initiated establishment of Sick Newborn Care Units for Rajnandgaon, Raipur, Durg, Raigarh, Korba, Koriya, Dhamtari, Bilaspur and Bastar. The renovation is over in Rajnandgaon, Durg, Bastar and Raigarh. Renovation is ongoing in Raipur, Korba, Koriya, Bilaspur and Dhamtari and there is budget deficit of Rs. 40 lakh which is requisitioned this year. Equipments are yet to be purchased. Again this year, in collaboration with UNICEF and NNF an assessment of current facilities is already done for Kawardha, Sarguja and Mahasamund district hospitals. The micro plans are prepared accordingly which include architectural outlay of the unit, equipments, manpower mapping, and bridging the capacity gaps. UNICEF will also supervise the renovation work so as that is as per NNF standards.

#### **Operational strategies:**

- An estimate of requirements in terms of number of neonatal beds and equipments is already done jointly by Office of Civil Surgeon of the District, Office of Chief Medical and Health Officer of the District, UNICEF and NNF.
- As per the requirement, renovation of the existing infrastructure is necessary in each of district level facility.
- Rajnandgaon renovation is been undertaken with support from UNICEF. Equipments that are not under the UNICEF rate contract list will be purchased through NRHM for Rajnandgaon.



- There are certain equipments that already exist with each of the facility in working condition. But these provide rudimentary care. Additional general equipments, equipments for individual patient care and side laboratory are required. The detail is already planned by CS, CMHO, UNICEF and NNF.
- Training of medical staff and para – medicals will be done by UNICEF with their resources – which are not budgeted in this PIP.

#### Budget estimate:

S. No	Unit Description	District Hospital, Mahasamund	District Hospital, Kawardha	District Hospital, Sarguja	District hospitals five district level hospitals	District Hospital, Rajnandgaon (in lakhs)
1	Renovation	29,00,000	30,00,000	31,00,000	40,00,000	130.00
2	Equipments	30,00,000	30,00,000	30,00,000		90.00
<b>Grand Total</b>						<b>139.00</b>

In addition, contractual staff will be appointed in the SNCUs of Rajnandgaon, Raipur, Durg, Raigarh, Korba, Koriya, Dhamtari, Bilaspur and Bastar with fixed remuneration per month. The staff for each unit will consist of four staff nurses (20 percent requirement of staff nurses). Rest of the staff for each unit i.e. one paediatrician, two MBBS doctors and six staff nurses will be managed from the hospital pool.

#### Table:

S. No	Unit Description	Unit cost	No. of Units	Duration	Total Cost (in lakhs)
1	Incentive for doctors	10000	9	9	8.10

#### A.2.3 Home Based Newborn Care/HBNC in Chhattisgarh

Facility based neo-natal care being improved through NRHM interventions like FRUs and 24x7 PHCs also needs to be complemented with home based interventions so that adequate number of referrals can reach the improved facilities and thus a further dent can be made in Infant Mortality of Chhattisgarh. Keeping these needs in mind, an HBNC initiative has been launched in 2009 under NRHM PIP in Chhattisgarh.



**Objectives:** In order to fulfil the overall goal of reduction in neo-natal mortality rate, the HBNC initiative in Chhattisgarh has the following operational objectives:

- Ensuring that Mitnin is present during all home deliveries
- Ensuring that each neonate is visited at least five times by the Mitnin in first four weeks
- Ensuring that all asphyxia cases are identified and treated by the Mitnin in case of home deliveries
- Ensuring that Mitnin identifies all suspected cases of neonatal sepsis
- Ensuring that the identified sepsis cases are referred to PHCs/CHCs having admission facility
- Ensuring that the facilities (PHCs/CHCs) are able to provide treatment for neonatal sepsis round the clock.
- Ensuring that the sepsis cases reaching the facility receive Gentamycin + Cotrimoxazole treatment fully
- Ensuring that the identified sepsis cases whose families are unable to go to facility, are able to reach the ANM to get Gentamycin injections; and if even that does not happen, receive full oral Cotrimoxazole dose from Mitnin
- Have clear baseline measurement of key indicators so that monitoring of impact is possible

#### **Operational Strategy:**

1. **Selection of HBNC Blocks:** HBNC has been launched in 18 blocks (one per each district) in December 2009. This initiative covers rural population of around 1.5 million. In each district, one Block with CHC functioning as FRU has been selected. Further, all the PHCs in the selected block are required to function as 24x7 PHCs with at least one trained service provider staying on-campus.
2. **Cash Support for enabling neonatal referrals:** Chhattisgarh has a large and capable human resource in the form of Mitnins who are ideal for HBNC interventions. Mitnins have already received training on some components of HBNC. Under the HBNC initiative, Mitnins will be encouraged to attend all deliveries happening in their respective habitations. One significant addition to their skills and equipment will be of asphyxia management through ambu-bag and suction. Mitnin will be expected to make at least 5 visits in the neo-natal period. She will identify neonates for signs of sepsis, administer first dose of oral Cotrimoxazole and refer them to the nearest PHC or CHC with well-functioning in-patient facility. Mitnins role in attending deliveries, asphyxia management, neo-natal home visits, making referrals and taking patients to facilities will be encouraged through cash incentives. She will



play a key role in overcoming social taboos against taking newborns out of home so that sick neonates can reach the facilities in time. Since traditional Dai plays a big role in home deliveries and neo-natal care and advice, she will also be provided with cash incentive for attending the deliveries and helping the Mitadin in aiding newborn survival. Further, rural families with sick neonates will be supported with cash so that they can reach the facilities on time following Mitadins advice. Efforts will be made to facilitate the transportation arrangements through the public health system and Mitadins. Once the family reaches the facility and the diagnosis gets confirmed by the trained health staff, the family will be expected to admit the neonate for 5-7 days. They will be provided with additional cash support for this stay. The family can choose not to admit the neonate and instead come each day to facility for treatment. But such cases will not be eligible for the additional cash support. In case the facility decides to refer the case further, additional cash support will be made available.

In case the family is unable / unwilling to take the referred neonate to a PHC/CHC, they can go to the local ANM and get sepsis treatment. If the family is not able to do even this, Mitadin will administer the full dose of oral cotrimoxazole. But for these fall back options, no cash support will be given to the family.

3. **Training of Mitadins:** All the Mitadins in the selected blocks are being trained through a 7 day module which is based on SEARCH modules and also complements the earlier Neonatal survival training received by Mitadins. In 2010-11, these Mitadins will go through a four day review and refresher module. Mitadins are currently learning the basic skills of HBNC. These skills will be reinforced by revisiting these topics and assessing their experiences during practicing the skills during last 4-6 months. They will be trained through setting up Block Training teams with help of State Health Resource Centre, Chhattisgarh. Mitadins will be supported on field and get supervised by the Mitadin Trainer, DRP cascade. Therefore all MTs and DRPs will also be trained in HBNC module.
4. **Training of Dais:** Since traditional Dais have a critical role in providing advice on newborn care, they will be provided 2-day training on neonatal care. This will also help in improving the Mitadin-Dai interface. Dai training will be done through BTTs.

#### **Annexure1: Roles of various human resources and support needed for each role**

Worker/Facility	Role
Mitadin	<ul style="list-style-type: none"> <li>Mitadin to be present at the time of all deliveries (if happening at home) and make at least 5 home visits for all neonates (including the ones born in institutions) during four week period after delivery</li> <li>To identify and treat asphyxia using ambu-bag and suction</li> </ul>



Worker/Facility	Role
	<p>pump</p> <ul style="list-style-type: none"> <li>To ensure through repeated home visits at critical junctures that advice on breastfeeding, keeping baby warm etc is followed by the family</li> <li>To identify sepsis and refer to PHC/CHC</li> <li>In case referred family not able to go to facility, refer to ANM for Gentamycin injection and if that also does not happen, administer full dose of Cotrimoxazole</li> </ul>
Dai	<ul style="list-style-type: none"> <li>To attend delivery (if happening at home) and help Mitnin in her task</li> </ul>
Mitnin Trainer	<ul style="list-style-type: none"> <li>To train Mitnins and provide on the job support and supervision</li> </ul>
DRPs and FCS	<ul style="list-style-type: none"> <li>DRPs to provide field level monitoring and strengthen skills of Mitnins through cluster meetings and demonstration</li> <li>FCs to supervise the DRP-MT team to ensure coverage with quality</li> </ul>
ANM	<ul style="list-style-type: none"> <li>To visit all newborns (less than 2 months old) on Immunization Day so that any neo-natal illnesses can be double checked for available cases</li> <li>To give Gentamycin injections if any family approaches the ANM for sepsis treatment of a newborn</li> </ul>
PHC	<ul style="list-style-type: none"> <li>To provide sepsis management (including Gentamycin injection) 24x7</li> <li>To refer complicated cases to specialist at CHC or District Hospital</li> </ul>
CHC	<ul style="list-style-type: none"> <li>To provide care if neonate reaches the CHC directly</li> <li>To provide management of complicated cases referred to them from PHCs</li> <li>To provide overall supervision and support to the programme</li> </ul>



### Activities for 2010-11:

1. Fund flow for payment of incentives to Mitanins for neonatal home visits and referral, for payment of cash support to families who bring referred sick neonates to facilities and for payment of incentive to Dais
2. Round 2 Training of 4 days of Mitanins in 18 blocks
3. Training of Dais of 2 days
4. Ensuring adequate treatment of referred sick neonates in health facilities in the selected blocks

Item	Frequency	No.	Rate	Amount (in lakhs)
<b>To be spent by State Health Society</b>				
Procurement of Mitanin HBNC Kits (for 7308 Mitanins in 18 blocks)	1	7308	1600	116.93
<b>Sub-total</b>				<b>116.93</b>
<b>To be sent to District Health Societies</b>				
Mitanin and MT Training Round1 (7days)	7	7668	200	107.35
Mitanin and MT Training Round2 (4days)	4	7668	200	61.34
Health Staff Training	3	900	400	10.80
Dai Training	2	3600	200	14.40
Mitanin Incentive- neonatal Home visits (for all newborn)	1	48750	200	97.50
Mitanin Incentive- Taking Identified Cases to PHC/CHC (20% of newborn)	1	9750	150	14.63
Cash Support to Family - Transport to First Referral (20% newborn)	1	9750	300	29.25
Cash Support to Family - 5-7 day Admission in Facility (10% of newborn)	1	4875	1000	48.75
Cash Support to Family - Transport for Second Referral (2% of newborn)	1	975	500	4.88
Dai Incentive (attending delivery at home, taken as 40% of deliveries)	1	19500	50	9.75
<b>Sub-total</b>				<b>398.65</b>
<b>To be spent by SHRC</b>				



Item	Frequency	No.	Rate	Amount (in lakhs)
ToT for Health Staff Orientation	2	108	600	1.30
ToT for skill training (asphyxia mgt.)	1	54	600	0.32
State ToT (Round 1)	7	15	450	0.47
Block ToT (Round 1)	7	144	450	4.54
State ToT (Round 2)	4	15	450	0.27
Block ToT (Round 2)	4	144	450	2.59
Mitanin HBNC Book	1	7668	50	3.83
HBNC Trainer Manuals (Round 1 & 2)	1	200	150	0.30
ToT for Dai Training	2	144	450	1.30
Baseline Survey	1	18	35000	6.30
State Level Training Development, Coordination, Monitoring Cost (15 months)	15	18	5000	13.50
<b>Sub-Total</b>				<b>34.72</b>
<b>Total</b>				<b>550.29</b>
<b>Amount Released in 2009-10</b>				<b>291.71</b>
<b>Amount Required for 2010-11</b>				<b>258.58</b>
Expected no. of deliveries in 18 blocks in 13months is 48750				

#### A.2.4 School Health Programme: "Swasth Pathshala Yojana"

##### Introduction:

In Chhattisgarh, as per NFHS III, anaemia in children amongst 6 to 35 months age is 81 percent. 52.1 percent children (under 3 years age) are underweight for their age. 45.4 percent children (under 3 years age) are stunted i.e. almost every second child is chronically undernourished. 18 percent of under 3 years children are wasted (too thin for height).

These under three children are going to be the school entrants. Malaria is one of the main causes of long absenteeism amongst schoolchildren. There is no comprehensive School health programme in the state as of now, though there were some school health check-ups and immunization and allied services.



*A comprehensive school health package that will create educated healthy citizens is the need of the hour. Healthy bodies will ignite healthy and creative minds that would be an asset to the state.*

## **Strategies**

### **1. Health Education in Schools:**

*Schools are the best place to inculcate healthy habits through behaviour development communication (BDC) rather than behaviour change communication (BCC) which is required for adults. School students can be the ambassadors of health carrying messages of health from class rooms to families and neighbourhood.*

*This dimension of school health is the “Empowerment process” in health that takes place in School among students and teachers and from them to the village community. This is through a continuing flow of information from the class room to families and to the kitchen where a continuum of education and resultant behaviour change of adult family members does take place. This information flow through students on health promotion including healthy life styles, prevention of diseases, seeking early referral for emergencies etc will be from the teacher of the school with a well functioning School Health Programme. Whether it is washing hands before handling food, keeping food covered to protect from flies or taking the infant regularly for immunization all are powerful messages that are carried by Child to families from the classrooms. This is not limited only to a one day exercise but will be an ongoing activity in school.*

*The health department will design IEC materials books and modules (similar to the Swasth Mitra of Rajasthan) to be printed by SSA/ NRHM distribute to the school.*

### **2. School Health Clubs:**

*There will be a mechanism to institutionalize school health activities as an ongoing activity in school through these clubs. This will be a joint team of teachers and students with periodical inputs and assistance from health staff.*

*The student component of School Health Clubs will be through peer leaders who will take initiative among students in coordination with one or two school teachers of School Health Clubs.*

***Capacity building of teachers will be done for detecting common ailments, administering first aid, delivering messages and demonstrating hand washing and personal hygiene during their routine educational training at DIET.***

*Couple of teachers will undergo a capacity building training by which they can identify early symptoms and signs of common illnesses prevalent in the locality, also fair knowledge of seasonal illnesses. Then the teacher can be on alert to pick up*



children with such early symptoms to refer such cases to the nearest private practitioner or government doctor for treatment. Intervention must be at the time of need.

### 3. Health Promotion & Disease Prevention in Schools:

3.1 It is estimated that there are 40 lakh children in 50000 Government school run by the state. (Primary to Higher Secondary School). Iron Folic Acid –Supplementation to all girl-schoolchildren of middle and secondary schools by the teachers with the help of health personnel. In addition to this IFA supplementation to the school-going adolescents, the school dropout will be covered as special initiative under convergence with WCD and SSA

3.2 Bi – annual de-worming in all children attending primary, middle and secondary schools

Biannual de-worming drive for all school from primary standard onwards shall be conducted. In Chhattisgarh there are around 40 lakh students' community who will be benefited from the biannual de worming drive that will be conducted jointly by health department and Sarva Siksha Abhiyan (SSA). The drug Iron Folic Acid and Albendazole Tablet will be purchased and administration of these drugs to the proposed beneficiary will be done in the presence of health staff like Supervisor, LHV/ ANM / BEE or Medical officer. The drive will be done in the month of August and January in a year. Tab Albendazole 400 mg – 80 lakh in quantity will be procured for de-worming by the health department.

3.3 Also in this drive health BCC sessions on personal hygiene, nutrition shall be held and general health check-up will be done by the trained teachers, health personnel.

3.4 Bi –annual testing of salt consumed at MDM for iodine content during SHISHU SANRAKSHAN MONTH (SSM). This is to create awareness on consumption of iodised salt. Salt testing kits will be procured by UNICEF.

### 4. School Health Check-ups:

Under the Swasth Pathshala Scheme complete screening of primary, middle, high school and higher secondary school students in the state will be undertaken.

This health screening can be an annual exercise or at entry level in Primary, Upper Primary or High School level which spaces it out to once in three to four year exercise.

The PHC doctor or RMA will hold screening camps where one ANM / LHV with some other assistants will support them in conducting this. The screening camps involve ophthalmic check up, de worming, health education, topics on gender sensitivity, anaemia check-up, basic dental check-up, referral to higher units according to necessity etc. The district can also utilize private doctors to conduct such camps.



During the school health check-up, the medicine and iron folic acid will be supplied from the directorate of health services.

The school health check up findings will be recorded in the prescribed individual cards printed by NRHM and for use by each student and teachers for future use. A standard referral format will be developed and used for referring cases to District hospitals or to specialists.

**Table: Estimated budget for Swasth Pathshala Yojana**

S. No.	Budget Head	Unit Cost (Rs.)	No. of Units	Multiplying factor	Amount (Lakhs)
	School health card	1.2	2000000	1	24.00
	Health Booklet	25	50000	5	62.50
<b>Total</b>					<b>86.50</b>

#### **A.2.5 Care of Sick Children and Severe Malnutrition**

As per NFHS III, 52.1 percent children (under 3 years age) are underweight for their age. 45.4 percent children (under 3 years age) are stunted i.e. almost every second child is chronically undernourished. 18 percent of under 3 years children are wasted (too thin for height). Under nutrition contributes to 53 percent of deaths in children of 0 to 5 years age group. (The Lancet, Vol. 361, June 2003). Children with severe acute malnutrition (SAM) are near to death and hence require urgent medical attention coupled with nutritional rehabilitation to save their lives. Also though the exclusive breast feeding till 6 months of age is good at 82 percent, only 54.5 percent children at age 6 to 9 months are started on complementary feeding. Thus, malnutrition starts 'setting in' at 6 to 9 months.

#### **Operational strategy:**

1. Baal Suposhan Yojana' is implemented only in high under nutrition districts.
2. Mid Upper Arm Circumference provided to all the ANMs, Mitanins and Medical Officers is applied for screening and provides visual impact to the parents on severity of their child's malnutrition status. This tape is used only for 1 to 5 years old children.
3. The Mitanins - AWW will receive a sum of Rs. 100 / - for accompanying the child to the PHC / CHC / Hospital.
4. All the Thursday's will be designated as 'Suposhan Diwas' when these referrals will be ensured and serious cases will be admitted in the PHC / CHC / Hospital.
5. All the Medical Officers will be trained in management of SAM where GOI guidelines of FIMNCI for treatment of Severe Acute Malnutrition will be used.



6. The tools for referral and reporting will be developed and implemented.
7. 5 beds will be allotted in 15 District Hospitals and 5 CHCs of these districts i.e. a total of 100 beds. A room will be allotted in each of these health institutions for these 5 beds. The room will be named as 'Suposhan Kendra'.
8. Each Bal Suposhan Kendra will be having a feeding demonstrator, cook and regular feeding facility for those children.

The budget that has been allocated of this head still remains unutilized so this year that money will be utilized hence no extra budget is necessary for this head.

#### **Estimated Budget:**

Funds are not requested from NRHM this year as the activity has recently been started and there is unutilised amount of **Rs. 50 lakhs**

### **A.2.6 Management of Diarrhoea, ARI and Micronutrient Malnutrition**

India has a national policy for management of diarrhoea among children under 5 years which recommends the use of Zinc tablets along with Lo - ORS in the treatment of diarrhoea as per the MOHFW, GOI directive dated 2<sup>nd</sup> Nov. 2006. The policy recommends for every case of diarrhoea, a dose of 20 mg/day for 14 days (even if diarrhoea has stopped) for children above age 6 months to 5 years and 10mg/day for 2-6 months.

UNICEF had supplied Lo- ORS and Zinc tablets in Rajnandgaon. The trainings were completed in the district through the RCH capacity building unit of SIHFW and implementation of the strategy has started in the district. At the same time, Zinc tablets are now available through BIBCOLD supply for eight districts and in the RCH kit supplied from GOI in all the districts. Trainings on revised diarrhoea management protocol (RDMP) are still remaining in 17 districts. These one day trainings are planned for this year and will be coordinated by RCH capacity building unit of SIHFW in association with Micronutrient Initiative – CINI. Prototype of IEC materials will be developed by UNICEF in consultation with Department of Health and Family Welfare and MI – CINI and the materials will be supplied by MI – CINI.

### **A.2.7 Navajati Sishu Suraksha Yojana (NSSK)**

The trainings for NSSK have been recently started in the State and one batch of two days training with IAP support has been conducted in December 2009. In 2010 – 11, the training will be conducted for personnel of health institutions that are conducting institutional deliveries. Thus in Chhattisgarh, out of 721 PHCs – 354 are conducting deliveries, out of 146 CHCs and 18 district hospitals- all are conducting deliveries and out of 4776 sub centres – 999 are accredited for conducting deliveries. For PHCs, four health staff - one each of Medical Officer, Rural Medical Assistant, Staff Nurse and LHV will be trained. For CHCs, five



health staff – two Medical Officers, one Rural Medical Assistant and two Staff Nurses will be trained. For sub centre, one ANM will be trained. For District Hospital seven health staff – two Medical Officers and five Staff Nurses will be trained. Thus a total of 3241 health staff will be trained for two days at the district level. Thus there will be 81 batches year. The RCH capacity building unit in SIHFW will be coordinating these trainings along with IAP at the district level. At the same time, these 1517 health institutions conducting deliveries (including FRUs and 24 X 7 PHCs) will be strengthened in equipments and recording and reporting system. On assessment currently, 721 health institutions need to be equipped with newborn corner (stabilization units). As the state is aiming for 75 percent institutional delivery this year (i.e. 525,000 deliveries), adequate quantities of recording material for newborns is also planned.

#### Partner support:

UNICEF will be providing display of (1) Golden one minute protocol, (2) Hand washing, (3) Kangaroo Mother Care and (4) formats for recording for each new born.

The training cost for NSSK is Rs.7762440 which is mentioned in training part (Reference A.11.5.5).The equipment cost is as follows:

#### Equipments for 721 health facilities

Equipments	Unit cost	No. of Units	Duration	Total budget (in lakhs)
Neonatal Ambu bag (450 ml, silicone, reservoir, Face mask '0' number, Face mask '1' number)	1000	716	1	7.21
TOTAL				7.21

Thus total budget required for equipment procurement is Rs. 716.32 lakh



## **A.2.8 Other strategies/activities**

### **A.2.8.1 Child Friendly Health Facility Accreditation:**

The initiation of breastfeeding within one hour of birth is 50 percent in Chhattisgarh (DLHS 2007 - 08). Now, as institutional deliveries are increasing in district hospitals due to Janani Suraksha Yojana, we have increasing newborns who are taking birth in a captive environment. It is expected that this would streamline the routine care at birth to some extent. Also paediatricians and staff nurses from nine district hospitals have been trained on infant and young child feeding practises. The accreditation of district hospitals is still remaining and would be taken up through the State task force (planned in February and March 2010). The accreditation will be coordinated by RCH wing jointly with UNICEF.

In 2010 – 11, it is planned to further take up this activity to all health institutions conducting institutional deliveries which is 1517. The Child Friendly Health Facility would fulfil the following criteria:

1. Have a written breastfeeding policy that is displayed in the health institution and communicated to all health care staff.
2. Train all health care staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding immediately after birth
5. Show mothers how to breastfeed and maintain lactation, even if they should be separated from their infants.
6. Practice rooming in – that is, allow mothers and infants to remain together 24 hours a day (Kangaroo mother care)
7. Give newborn infants no food or drink other than breast milk, unless medically indicated.
8. Encourage breastfeeding on demand
9. Give no artificial teats or pacifiers to breastfeeding infants.
10. Refer mother baby pair from rural areas to Mitnans who will encourage and promote exclusive breastfeeding for 6 months

**In addition, to the above ten criteria following will be followed:**

1. Each newborn will be assessed for danger signs within 24 hours of birth and on day 3 by IMNCI trained health worker. For this the mother baby pair will be admitted for at least 3 days after delivery in the health institution.



### **Objectives:**

- *To ensure minimum standard of services provided to the newborns and mother before discharge from the institution.*
- *Improvement in immunization services to the newborns.*
- *Imparting knowledge to mothers and families regarding child care.*
- *Empower the mother and family members to identify danger signs and life threatening conditions in neonates and infants and timely referral for timely care. (IMNCI)*
- *Birth registration for all the newborns.*
- *To reduce the morbidity and mortality in newborns.*

### **Key operational areas:**

- a) *Six days training will be imparted to a team of health staff including general duty doctors, Rural Medical Assistants, Staff Nurses, LHV (CHC) and ANM (CHC) at SIHFW. The training will be coordinated by RCH Capacity Building Unit of SIHFW. Funds from NRHM PIP 2009 – 10 for this activity will be utilised for the same. These Master Trainers will further train personnel of health institutions who conduct institutional deliveries. These trainings will be during the monthly meetings.*
- b) *Supply of one written breastfeeding policy boards to 1517 health institutions will be displayed in the maternity ward, Paediatric ward and in OPD/main entrance area of these CHCs.*
- c) *Supply one printed Infant and Milk Substitute Act boards to 1517 CHCs.*
- d) *Neonatal assessment case forms and registers will be supplied to all the institutions that conduct institutional delivery (refer budget item in Navajati Sishu Suraksha Karyakram Yojana activity).*

### **Areas of support:**

*UNICEF will be supporting in arranging training for health staff in CHCs.*



**Budget requirement:**

S. No	Budget Head	Unit Cost	No. of Units	Duration	Amount (in lakh)
1	Written breastfeeding policy boards	500	1517	1	7.58
2	Printed Infant and Milk Substitute Act boards	500	1517	1	7.59
<b>TOTAL</b>					<b>15.17</b>

**A.2.8.2 Swagath Package for Mothers and Newborns for institutional deliveries (A package of services for mothers and newborns)**

**Objectives:**

- Safe delivery under dignified conditions
- To ensure minimum standards of services provided to the newborns and mother before discharge from the institution.
- Improvement in immunization services to the newborns
- Imparting knowledge to mothers and families regarding child care
- Empower the mother and family members to identify danger signs and life threatening conditions in neonates and infants and timely referral for timely care (IMNCI).
- Birth registration for all the newborns.
- Malaria prevention for the mother and child
- To reduce the morbidity and mortality in newborns

**Implementation strategy:**

The 'Swagath Package' initiative will be implemented in all the health institutions where institutional deliveries are performed.

- 'Swagath package' will be delivered to all mothers and newborns admitted for institutional deliveries. It is estimated that due to JSY, the institutional delivery rate would be 75 percent in 2010 – 11. Under the package, the following services will be ensured before the discharge of mother and newborn:

- The new born will be immunized with BCG and OPV (zero dose).



- ii. PNC care for mother (post natal care) including IFA and standard medication
- iii. Advice regarding best child care practices (Breastfeeding, nutrition, hygiene).
- iv. Practices for prevention of prevalent diseases (ORS, danger signs, IMNCI)
- v. Confirmation of Provisional birth certification and details of obtaining birth certificate
- vi. Sanitary pads
- vii. Welcome letter along with JSY payment.
- viii. Cotton cloths for urine / faecal matter disposal – 12
- ix. Recipe booklet on high energy food.

b. The Mitadin from Mitadin help desk will delivery this package in close coordination with the staff from maternity ward and paediatric ward. This Mitadin will be provided training for one day on 'Swagath package'.

#### **Budget estimate:**

Rs. 2,25,00,000 is already available from the NRHM PIP 2008 – 09 and 2009 – 10 and this activity is already initiated in collaboration with State Health Resource Centre of the State. Hence no additional budget is required this year.

#### **A.2.8.3 Integrated bi – annual maternal and child health month (Sishu Sanrakshaan Maah)**

Chhattisgarh has been implementing a bi – annual health and nutrition months known in 'Sishu Sanrakshaan Maah' in the months of April and October. Seven such rounds have been conducted in October 2006, April 2007, October 2007, April 2008 and October 2008, May – June 2009 and November 2009. These rounds are also in conformation to the recommendations of National Workshop on Micronutrients organized by ICMR on the 24-25 November 2003 which recommended that Biannual Child Health and Nutrition Promotion Months be held, six months apart which would offer a package of child health and nutrition services of which Vitamin A supplementation, deworming and bi – annual systematic impregnation of bed net would be an integral part. The rounds are based on the globally known REACH strategy i.e. Regular Events to Advanced Child Health which focuses on providing contact points for delivery of child friendly health services to pre-school children. The integrated approach is also in conformity to the Village Health and Nutrition Day guidelines issued by MoHFW, GOI. The package of services given is as follows:



1. Administration of Vitamin A to eligible children aged 9 months to 5 years age to children who had not received Vit. A in the past 6 months in a bi – annual approach as per the guidelines of MoHFW, GOI (bi-annual activity)
2. Administration of vaccines to eligible beneficiaries– focusing on never or partially vaccinated.
3. Deworming of children aged 1 to 5 years age (bi-annual activity)
4. Providing iron folic acid tablet to all pregnant women and eligible children as per the recommendation from Secretary Health and Family Welfare, MoHFW, GOI (D.O No. Z. 28020/82/2006-ZH dated 25<sup>th</sup> November 2006)
5. Systematic bi – annual impregnation of bed nets in all districts (bi-annual activity)
6. Salt testing at the household of pregnant women for iodine content in October only.

As seen, those essential services are covered in these months that need to have a bi-annual approach. Also those services are covered that have poor coverage in the State.

For the initial rounds, UNICEF was supplying Vitamin A solutions, gap filling of Tablet Albendazole and developing training manuals, operational guidelines and IEC materials. The Micronutrient Initiative has been assisting the State in printing the manuals, guidelines and IEC materials. UNICEF and MI also had been monitoring the rounds. One State level Technical Consultant and four Divisional Consultants have been providing all the facilitative support to this initiative.

In the round of May – June 2009, the coverage with Vitamin A was 91 percent and improvement from the 68 percent coverage in the earlier rounds. Also the deworming coverage was 57 percent in May – June 2009, an improvement from 41 percent coverage in April 2008. It is documented that more number of pregnant women benefit from Sishu Sanrakshaan Maah in the two systematic rounds. Measles coverage was 11.3 percent of annual target in the last round, an over shoot of 3 percent indicating that backlog immunizations was also covered. IFA small coverage in the last round was 42 percent of annual target. Bed nets treated were 225000 in the last round and improvement from 48,200 in the April 2008 round. Salt samples tested in October 2008 round was 445000.

### **Operational strategy**

- Vitamin A and Tablet Albendazole will be procured and supplied at least one month before the rounds. Vitamin A is available in Kit A in rural that is supplied by GOI through UNOPS. However Vitamin A is not available in urban areas and will be procured separately through NRHM funds. Twenty percent of all the beneficiaries reside in urban areas of the State.
- Every ANM will be oriented for half a day on the activity one month before the round.



- A beneficiary wise list will be prepared by the ANM before the round in close coordination with AWW and Mitans.
- There will be strengthening of routine immunization micro plans as all the services will be delivered in the routine immunization sessions which are on Tuesdays. For any additional habitation, same services will be delivered on Fridays.
- ANM will administer Vitamin A and immunizations and provide Tab IFA and Tab Albendazole to eligible beneficiaries.
- The Malaria link volunteer or the Male Health Worker will impregnate the bed nets with 2.5% Deltamethrin solution which is supplied by the malaria dept.
- Special recording and reporting forms are developed integrating with the current reporting forms, on which the health workers report.
- Banners and posters designed by UNICEF in close coordination with the RCH wing (DoHFW) and MI will be printed and supplied to the district. There are 35,000 session sites in the state in these special months. Two posters and one banner per session site will be printed and supplied.
- Additional mobility support will be provided to ANMs for covering 16000 session sites that are hard to reach. Also, as coverage of essential package of services for child health are poor in urban areas, special session will be organised in these areas by deploying ANMs working in rural areas to the urban areas on special days – where all the package of services will be delivered. These urban sessions are 1200 in number.
- A social mobilization campaign will be run in the State in this month covering the print and electronic media that gives message of provision of essential maternal and child health services in these months.
- UNICEF and MI monitor the rounds and provide feedback to the dept to enable corrective actions

The following support will be from partners for the April and October 2010 rounds:

#### **Micronutrient Initiative:**

1. Print operational guidelines, formats for micro planning, record keeping, tally sheets, monitoring and bi annual strategy registers (Vitamin A and deworming).
2. Support in district and block level workshops, taskforce meetings and press conference
3. Support in inauguration of the SSM at state and district levels
4. Urban area mobilization through riksha raths, miking, FM radio, cable television etc



5. Social mobilization through involvement of local NGOs, wall writing, handbills, banners, posters etc
6. Improving service delivery in 27 high risk blocks of the state through special local level innovative strategies.
7. Award to best performing supervisors and health workers.

#### UNICEF:

1. Tab Albendazole (50 percent supply)
2. Developing operational guidelines, prototype of banners, posters
3. Monitoring in close collaboration with Micronutrient Initiative.

#### Budget estimates:

The budget estimate is for one round

S. No	Unit Description	Unit cost	No. Of Units	Duration	Total Cost (in lakhs)
1	Vit. A solution (bottle of 100 ml)	56	9000	1	5.04
2	Tab Albendazole (400 mg)	0.70	1200000	1	8.40
3	Tab IFA (adult)	0.12	9000000	1	10.80
4	Syrup IFA 100 ml/bottle (small)	15.00	2400000	1	360.00
5	Social Mobilization Activities like News Paper Advertisements during the month	500000	2 times in a month	1	5.00
6	TV Spots	500000	30 days	1	5.00
7	Mobility support for monitoring by district and block health officials	5000 per block+ district	146+18	1	8.20
8	Urban service delivery	25000	18	18	4.50
<b>Total for one round</b>					<b>406.94</b>
<b>Total for two rounds</b>					<b>813.88</b>



### A.3 FAMILY PLANNING

#### Objectives:

1. To achieve better contraceptive prevalence rate of 65, TFR of 2.1 and reducing the birth rate of the state.
2. To improve health services in order to meet the family planning needs at community level.
3. To ensure provision of family planning services at the convenience of people who need them.
4. To ensure adequate training to the service providers at various levels in order to ensure better service provision, maintaining quality standards and satisfying the clientele
5. To increase the male participation in family welfare activities.

**Table: couple protection status**

Activity	Achievement
CPR-Any modern method	49.1
CPR- limiting methods	53.2
CPR-Oral Pills	1.4
CPR-IUDs	0.8
CPR-Condoms	2.9
Unmet needs, spacing methods	10.5
Unmet needs, terminal	5.4

\*Source: NFHS- 3

**Table: progress status of sterilisation performance**

Year	Total Sterilization	Vasectomy			Tubectomy		
	Performed	Total	NSVT	VT	Total	CTT	LTT
2002-03	115298	2862	1060	1802	112436	32447	79989
2003-04	115848	3242	2301	941	112606	31860	80746
2004-05	124478	3788	2851	937	120690	35906	84784
2005-06	124499	6699	5653	1046	117800	37957	79843
2006-07	133094	6322	5276	1046	126772	39347	87425
2007-08	153836	9920	8397	1523	143916	44981	98935
2008-09	147039	12087	8677	3410	134952	57897	77055
2009-10 ( Till Nov 2009)	53867	710	3482	4192	49675	19843	29832



*In order to improve the situation, the state has planned the following strategies:*

#### **Strategies:**

- *Promotion of Terminal and limiting methods mainly focus on NSV and CTT, through fixed day services in peripheries and regular services at district level and selected Community Health Centres.*
- *Coordinated family planning activity with reputed private providers.*
- *Improving utility of spacing methods by widening IUD use and social marketing of contraceptives.*
- *Provision of terminal sterilization services in district hospital on daily bases and fixed day services at community health services.*
- *Functional CHCs to provide sterilization on a fixed day of the week.*
- *Strengthening the block CHCs and 18 district hospitals to capable of providing safe MTP services.*
- *Proper referral services in CHCs and District hospitals for timely diagnostics and referral in case of STI/RTI services.*
- *Every village would have one social marketing outlet, which would have supplies of condoms and OCPs without interruption throughout the year. These would be managed by partnership with a private distributor network with subsidy to make it viable to operate in low off take areas.*
- *All 24-hour paramedical and medical staff would be trained to provide basic clinical and counselling services for RTI and STI with basic investigations (side laboratory level).*
- *Social marketing for OCPs and condoms along with other health related commodities*
- *A focused IEC campaign to build up demand for these services, especially for NSVT.*
- *Training of personnel in essential skills on providing better family planning services, at all levels- on laparoscopic sterilisation, minilap, NSV and IUD insertion as well on contraceptive update- in order to keep to the quality norms and regulations at service provision.*

#### **Activities:**

- *Fixed Day Male Sterilisation Services in 70 CHC out of 146 blocks.*
- *Fixed Day Female Sterilisation Services in 70 CHC out of 146 blocks.*
- *Male Sterilisation Camps in all Districts and blocks, as they are organised regularly.*
- *Female Sterilisation Camps in all Districts and blocks, as they are organised regularly.*



- Female sterilisation services on fixed days basis will be organised in all district hospitals and selected blocks.
- Promotion of Spacing methods through BCC and social marketing.
- IUD Promotion through public health system as well as Private facilities and training of CHC/PHC doctors on 380A manikin IUD insertion.
- Mitanin to act as a contraceptive depot holder and provide supplied goods as required by the people.
- Training activity for all ANM in alternative methodology for CuT Insertion.

### Private Partnership on Family Planning Process

The private providers at state will be involved in promotion of IUD 380 A in the state. Advertisement for Expression of Interest will be called from private providers who after inspection by quality assurance cell of the district then accredited by state Government to provide 380 A IUD to public free of cost, but the incentive of Rs 20 instead of user, shall be paid to the provider here. The private provider will be given free supply of 380 A and Rs 75 per beneficiaries. The private providers will give full detail of the beneficiary to be crosschecked by the district authority. The advertisement cost will be taken for IEC cost allocated to the Districts. Chief Medical and Health officer will be accreditation authority to accreditate the private facilities and to establish the quality cell in each district. .

**Budget Estimation:** This is covering only the essential family planning measures, not the entire activities planned. For rest of the activities, appropriate budget heads shall be used to pool necessary allocation.

**Table 2.23: Budget estimation for public private initiatives in family planning**

Budget Head	Unit	Facilities	No. of units	Unit Cost	Duration	Total (in lakhs)
Wages compensation for Female Sterilization beneficiaries	Per Beneficiary	Public	160000	1000	1	1600.00
		Private	20000	1500	1	300.00
Wages Compensation for Male Sterilization beneficiaries	Per Beneficiary	Public + private	20000	1500	1	300.00
NSV Camp		Camp	20000	--	400	0.00
IUD incentive beneficiary	Per	Public	125000	20	1	25.00



Budget Head	Unit	Facilities	No. of units	Unit Cost	Duration	Total (in lakhs)
	Beneficiaries	Private	15000	55	1	11.25
		Total	140000	40	1	56.00
Annual maintenance of laparoscopic machine in the district where machine and surgeons are available	District		11	2000000	1	22.00
Grand Total						2314.25

Note: - \* and \*\* Rs 1500 with breakup of Rs. 800 for beneficiaries, Rs 500 for institution (Private Nursing Home and Rs. 200 for Motivator.

**Table 2.24: Budget estimation for maintenances of OT and Instrument**

S. No.	Unit Description	No. of Unit	Unit Cost	Duration	Total Cost (in lakhs)
1.	Maintenances of OT	18	10000	1	1.80
Total					1.80

### Other activities

#### 1. Fixed day strategy:

To enhance family planning activities on fixed days particularly for the first six month of the financial year performance based incentives are proposed @ Rs. 50 / Case for ANM, Rs. 50 / case for Mitandin and Rs. 100 / case for surgeon for both male and female sterilization. Total numbers of cases from April to September will be 30000

#### Estimated budget

S. No.	Unit Description	No. of Unit	Unit Cost	Duration	Total Cost (in lakhs)
1.	Incentive for <b>Fixed day services</b>	30000	200	1	60.00
Total					60.00



## 2. NSC Kit

### **Procurement of NSV Kit to provide NSV kit in 146 Community Health Centres and 15 District Hospitals of Chhattisgarh**

S. No.	Unit Description	No. of Unit	Unit Cost	Duration	Total Cost (in lakhs)
1.	Procurement of NSV Kit	--	1000000	1	10.00
Total					10.00

**Table 2.25: Budget estimation for Procurement Laparoscope**

S. No.	Unit Description	No. of Unit	Unit Cost	Duration	Total Cost (in lakhs)
1.	laparoscope	40	500000	1	200.00
Total					200.00

## **A.4 Adolescent Reproductive and Sexual Health / ARSH**

Even if adolescent comprise 22% of the total population of the state, majority of them are still left out to avail qualitative health services including counselling and essential treatment from the state. There has been direct correlation between the awareness generation on adolescent health and reduction in maternal mortality, infant mortality, morbidity rate, malnutrition, and population control, reduction in high-risk behaviour and reduction in teenage pregnancy. For this focus has been given on adolescent health under RCH-2.

The health status of the women in state is alarming and needs immediate attention and address. Indicators like percentage of women suffering from anaemia (57.5%), percentage of women who were married at 18yrs or above are only 50.5% and total percentage of population suffering from sickle cell anaemia in the state is 18% (carriers 15% and diseased 1.2 %) are showing negative trends and demoralizing picture.

We all know that use of services by adolescent is limited. Poor knowledge and lack of awareness are the main underlying factors. Service provision for adolescent is influenced by many factors. For example, at the level of the health system, lack of adequate privacy and confidentiality skills, are barriers that limit access to services. Shortcoming in their



professional trainings often results in service providers being unable and sometimes unwilling to deal with adolescent in an effective manner.

In context of the Reproductive and Child health (RCH) programme goals, with special reference to the reduction of IMR, MMR and TFR, addressing adolescent in the programme framework will yield dividends in terms of delaying age of marriage, reducing incidence of teenage pregnancy, prevention and management of obstetric complications including access for early and safe abortion services and reduction of unsafe sexual behaviour.

#### **Objectives: -**

- To improve the health awareness in the adolescent age group on personal hygiene, nutrition, anaemia, sexual and reproductive, RTI and STI, health services etc.
- To make the adolescent health care facilities as well as safe abortion services accessible to handle the problems of unsafe adolescent pregnancies and management of reproductive tract infections easily accessible to all.
- To identify and reduce anaemia among adolescents.
- To reduce malnutrition and anaemia amongst adolescent's especially adolescent girls.
- To increase the awareness regarding pitfalls of early marriage and child bearing, regarding family planning and nutritional requirements of adolescents.
- To Increase awareness of one's own body (physical, psychological and reproductive health etc) and control over it – including fertility control and safe sexual practices.
- To provide easily accessible and friendly health care services and counselling for adolescents.

#### **Strategies:**

1. ARSH services to be made available in all facilities in a phased manner.
2. Major effort to screen for and manage anaemia and malnutrition in adolescence and where relevant for sickle cell anaemia. (Activities for this will be done under a separate component)
3. Distribution of IFA tablets and deworming tables in schools under school education program to manage anaemia in defined adolescent age group. (First phase in government school)(Budget for this will be booked under Sickle cell Anaemia Budget)
4. Higher secondary school based adolescent health education initiatives by building a local cadre of trained students on life skill education. Awareness on contraceptives methods to enable well informed choices



5. *Counselling and peer education programmes in haat bazaar through ARSH counselling centres (Sakhi /Sakha Kendra) as well as counselling of the family members of the adolescent age group.*
6. *Filling the skill gaps in health personnel for Adolescent Reproductive Sexual Health (ARSH) and other adolescent health interventions through rigorous training.*
7. *BCC interventions on adolescent health issues, through regular media and interventions by Mitanins.*
8. *Social marketing of sanitary napkins and other adolescent health friendly goods.*
9. *Intersectoral convergence with the ICDS and Education department*

#### **Activities:**

1. *Training of peer educators will be conducted by using the available training force.*
2. *Mother NGOs of the area will be involved in community outreach programs to disseminate information to adolescents in groups through various methods including sports events and film shows in villages. Vocational training institutes and other adolescent hangouts will also be targeted for activities by NGOs to maximize the chances of having an interface with the school adolescents.*
3. *Sakhi/Sakha Kendra: Staff of selected CHCs preferably will be trained on adolescent and reproductive health issues to counsel adolescents. The purpose behind this is to organize ARSH Clinics (Sakhi/Sakha- Kendra) in the identified haat bazaar (markets) of the villages at the block level. In the initial phase, at least one session per month would be organized by ARSH Clinics (Sakhi/Sakha Kendra.) lady health visitor to will be the focal coordination person for this activity. Their responsibilities would be to look after mobilization part and the functionality of these clinics in coordination with the ICDS, AWW. The activities of these ARSH Clinics would be counselling and peer education with the help of lady visitor on the haat bazaar day at the block level. One of the major roles of the LHV is to organize meeting at the hamlet level with the support ANM of Mitanins and AWW trainers to screen out the cases related with reproductive and sexual health. The purpose of organizing the screening at the hamlet level is to provide an opportunity to them to alleviate their doubts and queries related with the issues and seek for a proper address to it. Operationalisation of these Kendra will be collectively done by CHC staffs, Mitanins Trainers and Mitanins. Operationalisation of Sakhi/Sakha Kendra will be done in two phases: -*
  - *Phase 1 (In initial two to three months): - Awareness generation on personal hygiene (adolescent growth and development, menstruation and making of sanitary napkins at local level), counselling and distribution of IFA tablets for anaemia, treatment and counselling on contagious disease like itching,*



answering the queries of adolescent girls, distribution of deworming tablets, awareness on DOTS under T.B control programme.

- Phase 2(After the completion of first phase): -Treatment and counselling on reproductive health, immunisation of the identified left out adolescent girls, treatment and counselling on premature pregnancy and complications during delivery and pregnancy.

4. Training of adolescent group in schools on life skill education. The purpose behind this is to create master trainers at the state level, which in future will serve as a resource force to build local level cadre on adolescent reproductive sexual health (ARSH). In the initial phase, the program will be implemented on a pilot basis. We will initiate the activities in 4 government schools of two districts. Priority will be given to take up the tribal districts in the initial phase (Sarguja and Jagadalpur). Four batches of 15 girls each from four schools will be trained on life skill education to tackle the problems of adolescent health. Training of these batches will be done by state level resource persons (4 resource persons at the state level). On an average, these trainers will be involved for 20 days in a month to train the batches in the schools. The capacity building of these resource persons will be done by SIHFW. Later on as the program progresses, it will include trainings of adolescent boys too. In the next phase of implementation, the focus will be to take this program forward at the block level. The state nodal officer will be identified. The program shall work under the supervision of the Director of Health Services, Chhattisgarh.
5. Adequate support to be provided for mobilisation and success of Camps organized by women and child development department under Kishori Shakti Scheme and by Red Cross/DHS under sickle cell control programme. The latter will be organized to do the screening of adolescents for anaemia. All adolescent girls will be targeted for this activity. ANM will be sensitised to ensure the complete coverage. This approach will address the problem of iron deficiency and prevent sickle cell anaemia. The role of counsellors, apart from counselling will be to help the adolescents referred to the PHC /CHC for lab testing and drugs dispensing.
6. IEC campaign through print and mass media to reinstate messages of postponing childbearing and marriage age and to focus on nutritional needs of the adolescent group, will lead to the improvement of the status of malnutrition and postpone the age of marriage.
7. Counsellors trained in 2006/07 and 2008 shall conduct counselling of the adolescents once a month in the Govt PHC/CHC/Urban Health Centre. Along with this the focus will also be given on family counselling of members of adolescent age group
8. "Kishori Samuh" formed in each village needs to be strengthened through refresher training. Required coordination shall be done with ICDS and Education department.



9. Distribution of IFA tablets in schools (DOTS) to manage the anaemia level in adolescent age group.

10. Coordination with various departments and programme on similar issues.

In the initial phase of the programme, it has been decided to implement Sakhi/Sakha Kendra in 12 districts (Bastar, Kanker, Dantewada, Kawardha, Koriya, Jashpur, Korba, Raipur, Sarguja, Narayanpur, Bijapur, and Raigarh) of the state.

Activities to take up Sakhi/Sakha Kendra are as follows

- Identification and preparation of the list of villages where weekly markets (haat bazaar) are held. Along with this preparation of the list of ICDS workers, female teachers and LHV, ANM, and Mitadin trainer.
- Framing of the guidelines, preparation of training module and budget for the operationalisation of "Sakhi treatment and counselling centres"
- One day training of the supervisors, LHV, selected ANMs Mitadin trainers and female teachers before operationalising "Sakhi treatment and counselling centres" in the selected districts
- To initiate the "Sakhi treatment and counselling centres" in the first phase of the programme in the blocks of Kanker and Bastar districts

#### Budget:

S. No.	Unit Description	No. of Unit	Unit Cost	Duration	Total Cost (In Lakh)
1	Printing of Educational Books ARSH	5000	20	1	10.00
Total					10.00

#### A.5 Vulnerable Groups: Particularly Vulnerable Tribal Groups (PTGs)

Particularly Vulnerable Tribal Groups (PTGs) which were earlier called Primitive Tribal groups are those tribal groups which have been identified as the most vulnerable amongst tribal communities. They were identified by Government of India, first in 1975-76 and thereafter in 1993. The criteria for identification of such PTGs were:-

- (i) Pre-agricultural level of technology
- (ii) Very low level of literacy
- (iii) Declining or stagnant population



Based on above criteria, 5 tribal communities (Baiga, Pahari Korba, Abujhmara, Birhor and Kamar) have been identified as PTGs in Chhattisgarh. They are spread over a Number of districts like Sarguja, Jashpur, Narayanpur, Kawardha, Bilaspur, Raipur, Korba and Raigarh.

**Current status**

One of the distinguishing characteristics of the PTGs is their declining or stagnant population. The main reason behind this is the high levels of mortality amongst these tribes. The 10th Five Year Plan of the Government of India describes the problems of these vulnerable communities: ‘A decline in their sustenance base and the resultant food insecurity, malnutrition and ill-health force them to live in the most fragile living conditions and some of them are even under the threat of getting extinct.’

The issues of health and nutrition are very severe in these communities. A number of studies have calculated the malnutrition status amongst children and adults from PTGs and all the studies found very high levels of malnutrition among PTGs. E.g. One ICMR study has found 90% malnourishment among Kamar preschool children. Another study found severe malnutrition as high as 24% among Baiga children.

As we can see in the following tables, the IMR is more than double of India and the crude death rate (CDR) is much higher than India. The death rate of PTGs in Chhattisgarh is very high and fertility rate is higher than rest of Chhattisgarh and nearly the same as India.

Indicator	Birhors	Kamars
Birth Rate	34.8	32.9
Death Rate	17.6	14.5
Growth Rate	17.2	18.4
IMR	154	155.4

(Some aspects of population growth of the primitive tribes of Madhya Pradesh, Dr. G.D. Pandey and Mr. R.S. Tiwary, Journal of Family Welfare, Vol. 46, No. 2, October 2000)

A study on Hill Korba of Chhattisgarh reiterates the high mortality as indicated below:-

Statistic	Hill Korba	Chhattisgarh	India
GFR	129.2	-	125.2
TFR	3.01	2.79*	3.2**



CBR	28.23	25.2	26.1**
CDR	11.9	-	8.7**
IMR	166	80.9*	70**
Sex ratio	916	990*	933**

Source: \*\*SRS 1991; \*2001 Census of India

*(Socio-demographic profile of Hills Korba of Chhattisgarh, Sandeep Sharma et al, Indian Journal of preventive and social medicine, vol. 38, No. 3 and 4, July-Dec, 2007)*

The diseases that affect the PTGs are mostly similar to other tribal groups but the severity and prevalence of the disease increases due to malnutrition and lack of access to adequate health services.

As a strategy for curtailing the decreasing population, in 1978, Madhya Pradesh/Chhattisgarh state government banned sterilization among these tribal groups. But as we see in the above analysis, decreasing population is due to the high mortality amongst the PTGs rather than low birth rate. Such a discriminatory policy needs to be abolished and more focus has to be given on improving access of PTGs to health services.

### Objectives

- Improvement of health status of Particularly Vulnerable Tribal Groups in the state
- Decline in mortality rate of PTGs

### Key strategic actions

- Improving access of PTGs to public health services
- Empowering PTG Mitanins to provide hamlet level support to PTG families
- Provision of free health insurance cover to all PTG families

### Activities

- **Social mobilization of PTG Mitanins-** This is an exercise in which the PTG Mitanins will be encouraged to share their problems and then be facilitated in planning for their hamlets. This exercise will require involvement of all health personnel (ANM, BMO, MOs etc) and ICDS staff (AWW, Supervisor) in order that they too are sensitized to the plight of PTGs.



- **Coverage of all PTG families under Rashtriya Swasth Bima Yojana-** A survey of all PTG families will be conducted and all PTG families will be brought under RSBY irrespective of their BPL status so that they do not incur any expenses in health care in case of hospitalization.
- **Special health camps in PTG clusters/villages-** These will be outreach health camps specifically held in PTG villages/clusters which will be mapped out first. These camps will provide health services in the areas and families which are otherwise underserved.

### Indicators

- Number of PTG Mitanins mobilized
- Number of PTG families covered under RSBY
- Number of PTG patients who have received medical health during health camp
- Number of health camps held in PTG cluster/village

### Budget

SN	Activity	Numbers	Unit cost	Total (Lakh)
1	Social Mobilisation of PTG Mitanins	500	300	1.50
2	Coverage of all PTG families under RSBY	20000	800	160.00
3	Special Camps in PTG clusters	100	5000	5.00
	<b>TOTAL</b>			<b>166.50</b>

### A.6 Innovations/ PPP/ NGO

#### Current Situation:

The programme implementation as of now needs gearing up in the state- the steering committee meeting was held and it has decided to have a multidimensional focus on the issue and to move forward.

- Appropriate bodies at district and block levels formed, meetings needs to be regularized and their capacities need to be enhanced
- Mass awareness Programmes through various electronic/print/visual media as well as through electricity and telephone bills/percolated messages done.



- The media like government post card envelop, inland, electricity bills will have printed slogans on PNDT and a film on PNDT will be used for generating public awareness.
- Orientation for various organizations like NGO, development bodies, government officials have been taken up.
- NGO support and participation needs to be expanded.

### **Strategies:**

- To ensure NGO support in 4 regions for rapid identification of cases- in the case such NGOs are not available, allocation of this sum CMHOs to undertake the above tasks themselves
- Support for coordinating functions at Directorate of Health Services to organize sensitization program at District and Block Level personnel. The sensitization will be on following topics
  - Present scenario of PNDT Act,
  - Different records and its maintenance under PNDT Act
  - Provision of punitive action, the concerned authority and its power
  - Creation of a committee and its responsibility
  - Coordination with other enforcing department

### **Activities:**

- Regular meetings, monitoring and follow up of the appropriate bodies
- Active verification of adherence to norm by registered facility, finding out non-registered service providers, if any
- NGO support in 4 regions for rapid identification of cases- to implement last year's component
- Support for coordinating functions at Directorate of Health Services

**No extra budget requirement is proposed for the current financial year, as the previous year's budget will be utilized for meeting the expenses required.**



## A.7 Infrastructure & Human Resources

### A.7.1 Contractual Staff & Services

#### A.7.1.1 ANMs: Appointment of 2<sup>nd</sup> ANMs:

As NRHM is sanctioning 2 ANMs per sub centre, they can be appointed under NRHM activity. Last year's budget of Rs. 36840000 will be utilized in this year. Similarly, in current year total 110 second ANM (Assistant ANM) are projected to be recruited and trained. The Budget can be drawn from NRHM Flexi-pool. The detail can be seen in the part B of this PIP.

In Chhattisgarh 908 sub centres are vacant there is no ANM so we can't appoint second ANM until the vacant positions are fulfilled. In the appointment of second ANM, priority will be given to those centres where position of MPW (male) is filled.

*Budget Required*

No. of ANM	Monthly salary	Duration (months)	Total cost (lakh)
290	6000	12	208.8
110	6000	6	39.6
Total cost			248.4

**Fund available from previous year under this activity is Rs. 174 lakh.**

**Therefore, fund required for this activity in the current year will be Rs. 74.4 lakh.**

#### A.7.1.2 Major civil works for operationalisation of 24 hour services at PHCs: Renovation of labour room

PHC is one of the most important institutions in respect of institutional delivery, as per the old PHC building plan there is lack of labour rooms and wards in several PHCs. Some labour rooms in PHC are too old so it need renovation, An extensive appraisal and mapping undertaken in the district to find out the gap of labour rooms and in the PHC which can be seen below, this gap is planned to filled through NRHM support. There are 18 districts which has been divided in to 3 groups as per the priority ,LWE district , underdeveloped districts and developing districts., priority has been given to the districts where there is huge gap of labour rooms during the year 2010-2011 it is planned to construct/ renovate 208 labour rooms at identified PHC.

Likewise there are 25 CHC has been identified by the districts for constructions / up gradations of labour rooms which is given below.



### Budget for labour room Renovations

S. No.	District name	Labour extension proposed in PHC	Room in	Fund Required for Proposed in PHC	Labour Room CHC	Fund Required CHC
<b>LWE District</b>						
1	Bastar	11		22.000		
2	Narayanpur					
3	Dantewada	16		160.000		
4	Bijapur					
5	Kanker					
6	Sarguja	69		103.500		
7	Rajnandgaon					
	<b>Sub Total</b>	<b>96.000</b>		<b>285.500</b>	<b>0</b>	<b>0</b>
<b>Under Developed District</b>						
8	Bilaspur					
9	Janjgir				8	16.000
10	Korba	37		37.000	3	12.000
11	Raigarh	19		57.000	13	26.000
12	Jashpur					
13	Koriya	6		18.000		
14	Kawardha	2		10.000	1	5.000
15	Mahasamund					
16	Dhamtari	10		15.000		
	<b>Sub Total</b>	<b>74</b>		<b>137</b>	<b>25</b>	<b>59.000</b>
<b>Developed District</b>						
17	Raipur					
18	Durg	38		285.000		
	<b>Sub Total</b>	<b>38</b>		<b>285</b>	<b>0</b>	<b>0</b>
	<b>G. Total</b>	<b>208.00</b>		<b>707.50</b>	<b>25</b>	<b>59</b>

**Total budget required for PHC is Rs. 707.50 lakh and for CHC 59 lakh total Rs.766.50. for the year 2010-2011**



## A.8 Implementation of PNDT Act:-

The PNDT Act in the state is carried out in the state. Appropriate bodies for monitoring of the PNDT Act has been formed at district and block level as per guideline. Mass awareness campaign is doing both at district and block authorities by dissemination of message that "SAVE THE GIRLS CHILD SAVE THE NATION".

### Strategies and activities:-To ensure the Implementation of PNDT Act

- Reorientation of committee member.
- Sensitization of doctors/ authorities of diagnostic centres or clinics through workshop/symposium one in each district.
- To generate awareness amongst school students through One Time debate/ painting competition and other activities and award to the winners at Block level.
- Grant in aid to the civil society partner/ NGO/ Mahila Samaj Seva Sansthan who is directly involved for above mentioned programme with active participation of government Partner. This grant will be for one time activity to the Sansthan.
- IEC/BCC at state level

### Budget Requirement:-

Activities	Unit	Unit Cost	Total Budget (Rs in lakhs)
District Level Workshops	18	7500	1.35
Block Level Debate at School	146	2000	2.92
Grant in Aid	2	10000	0.20
IEC at state level	1	53000	0.53
Total			5.00

## A.10 INSTITUTIONAL STRENGTHENING

### A.10.1 Human Resources Development

### A.10.2 Logistics management/ improvement

### A.10.3 Monitoring & Evaluation / HMIS

### A.10.4 Sub Centre Rent and Contingencies



## A.11 TRAINING

### A.11.1 Strengthening of Training Institutions

### A.11.2 Maternal Health Training

#### A.11.2.1 Skilled Birth Attendance / SBA

The maternal mortality ratio of Chhattisgarh is quite high when compared to other states. Inadequate infrastructure along with shortage of skilled service providers contributes to high MMR.

ANM /LHV/Staff Nurse plays a vital role in providing maternal care services especially in rural areas. It is therefore essential that they should be given proper training to ensure quality services to rural population. The state plans to train approximately 5800 Staff Nurses, ANMs & LHVs working at centres where institutional deliveries happen. Since this is a huge training load & the duration of training of each batch is 21 days with a small batch size of 4 trainees per batch, we plan to scale up this training in a phase wise manner. The state already has 931 health service providers trained in 15 days- SBA training. For 21 days- SBA training, first priority will be given to 1427 centres which include 18 district hospitals, 56 first phase units, 354 PHCs (identified as 24 \* 7) & 999 SHCs accredited as institutional delivery sites under JSY. From these 1427 centres, a total of approx. 1500 staff will be trained in first phase. Out of these 1500 service providers, 380 are expected to complete training in 2009-10. The plan for 2010-11 includes SBA training for another 554 Service providers, for which a budget of Rs. 1,46,88,770 is proposed . The training of rest 566 trainees is planned in 2011-12 to complete the training load of priority one centres. For printing of books an amount of Rs. 2,20,000 will be required .

#### Budget Estimation of SBA training:-

Description Of Training	No. Of Units	No. Of Batches	Cost Per Batch	Total Budget
1	2	3	4	=(3*4)
SBA Training Of SNs + LHVs + ANMs at Districts with Training Centres @ Rs.101430 per batch	320	80	101430	81.14
SBA Training Of SNs + LHVs + ANMs at Districts without Training Centres @ Rs.111430 per batch	234	59	111430	65.74
Total Budget	554	139	146.88	



### Budget Calculation Per Batch for SBA Training

Heads of Expenditure /Batch size	Cost per Batch for Districts with ANM training centres	Cost per Batch for Districts without ANM training centres
DA* (Rate x No. of Days x No. of Participants) (Rs.400 x 21 days x 4 no. of participants)	33600	33600
Honorarium (In House Faculty) (Rate x Days of training x no. of trainers) (Rs.200 x 21 days x 4No of trainers)**	16800	16800
Incidental Exp. like study material , course material, Photo copying, job aids, flip charts, LCD etc. (Rate x Days of training x no. of trainees) (Rs.250 x 21 days x 4 no. of trainees)	21000	21000
Working Lunch, Tea & Snacks (Rate x Days of training x no. of trainees) (Rs.200 x 21 days x 4 no. of trainees)	16800	16800
Sub Total	88200	88200
IOH @15% of Sub Total	13230	13230
Total	101430	101430
Venue Hiring Charges	0	10000
TA	From State Govt. budget as per norms	From State Govt. budget as per norms
TOTAL	101430	111430

#### A.11.2.2 BEmOC Training

The purpose of this training is to enhance the capability of MBBS doctors posted at 24 X & PHCs, to enable them in identifying and managing basic obstetric complications and develop necessary skills and competencies to provide essential obstetric & newborn care at the point of first contact. This training will ensure that each & every woman have access to basic & emergency obstetric care at delivery points, for early recognition of complications of pregnancy & labour, thereby timely referral to FRUs providing EmOC services. This will in turn help in reducing maternal mortality & morbidity. The training load projected for 2010-



11 is 150 medical officers posted at selected 354 PHCs (24 X 7). They will be trained as per GOI guidelines at selected six District training centres: District Hospital Durg, Rajnandgaon, Kanker, Bilaspur, Raigarh, and Sarguja. A three day TOT cum orientation training of 12 master Trainers (@ two MTs per training site) will be conducted at SIHFW.

Description Of Training	No. Of Units	No. Of Batches	Cost Per Batch	Total Budget (lakh)
1	2	3	4	=(3*4)
TOT on BEmOC of District Level Gynaecologists on from selected 6 Districts	12	One	61410	0.61
Training Of Medical Officers in Basic Emergency Obstetric Care (BEmOC)	150	30 ( @ 5 MOs per Batch)	100850	30.25
Total Budget Required				30.86

Budget Calculation for BEmOC Training			
Heads of Expenditure /Batch size	Cost per Batch	Cost For 30 Batches	TOT
DA* (Rate x No. of Days x No. of Participants) (Rs.700 x 10 days x 5 participants)	52500	1575000	25200
Honorarium (In House Faculty) (Rate x Days of training x no. of trainers) (Rs.200 x 10 x 4 )**	4000	120000	12000
Incidental Exp. like study material , course material, Photo copying, job aids, flip charts, LCD etc. (Rate x Days of training x no.	12500	375000	9000



of trainees) (Rs.250 x 10 x 5)			
Working Lunch, Tea & Snacks (Rate x Days of training x no. of trainees) (Rs.200 x 10 x 5 )	10000	300000	7200
Sub Total	79000	2370000	53400
IOH @15% of Sub Total	11850	355500	8010
Total	90850	2725500	61410
Venue Hiring Charges	10000	300000	
TA	From State Govt. Budget as per Norms	From State Govt. Budget as per Norms	From State Govt. Budget as per Norms
Total	100850	3025500	61410

### A.11.2.3 EmOC Training

Pregnancy is not a disease and pregnancy related mortality is almost always preventable. Every minute somewhere in the world, most often in a developing country, a woman dies from pregnancy related complications and child birth. A woman's death is more than personal tragedy; it represents an enormous cost to her family, her community and her nation. There is the largest disparity between the developing and developed nation in terms of health statistics with maternal mortality being the single most dominant factor. In Chhattisgarh state the maternal mortality is 335 per lakh live birth.

**The major causes of maternal mortality are**

- Haemorrhage
- Sepsis
- Anaemia
- Obstructed labour and
- Hypertensive disorders



All of these causes are mostly preventable through proper understanding, diagnosis, and management of labour complications. To prevent maternal deaths it is essential to strengthen primary health care infrastructure; antenatal, intra and post natal care in community by trained personnel. Quality antenatal care is a right of every woman.

### **Need for Emergency Obstetrics Care (EmOC) provider**

1. Availability of trained EmOC care round the clock is necessary because most of the complications cannot be predicted and prevented. Therefore, all pregnant women are at risk, e.g. we cannot predict pregnancy related haemorrhage as this may occur at any time during the pregnancy.
2. Role of antenatal care in preventing maternal death from infection is limited.
3. To avert maternal deaths from sepsis it is important to have clean delivery kits made available and care providers sensitised with appropriate health education.
4. As for obstructed labour, treatment including caesarean section must be made available to all women.
5. Complication from unsafe abortion can be treated well in a well equipped and well staffed health facility.

An agreement has been signed between the State Health Society and The Federation of Obstetric and Gynaecological Societies of India (FOGSI) to develop capacity of the Medical officers Non-Specialist posted in CHCs upgraded as FRUs in Chhattisgarh to provide high quality Comprehensive emergency obstetric care. In the coming years, the responsibility of training of master trainers and medical officers has been entrusted to FOGSI.

The scope of the MoU is to set up 2 Tertiary Care Training Centres in Chhattisgarh at Pt. JNM Medical College Raipur and JLN hospital and Research Institute Bhilai and to train 4 Master Trainers from each institution at CMC, Vellore. Along with this, there is a setup of 8 District Training Centre at District Hospitals of Durg, Rajnandgaon, Raipur, Korba, Raigarh, Ambikapur, Bastar and Bilaspur hospitals. FOGSI will be responsible for finalizing dates for the training of the trainers at CMC Vellore. This year 8 master trainers from both medical colleges have completed CTS & MODCAL training. 03 District Level Master Trainers have completed their training & 13 more district hospital master trainers are expected to complete it by end of this year. The expected outcome in the year 2010-11 is at least 32 medical Officers will be trained batch wise @ 8 MOs per batch. An amount of Rs 96000/- will be required for conduction of Tier III examination. The budget requirement for this is as below:-



### Budget Estimation of EmOC Training:-

Description Of Training	No. Of Units	No. Of Batches	Cost Per Batch	Total Budget (lakh)
1	2	3	4	=(3*4)
Training Of Medical Officers In Emergency Obstetric Care Program	32	4	1254420	50.18
Expert Examiners Cost	1	4	24000	0.96
Certification Cost of earlier EmOC trained Medical Officers	45		10000	4.50
				55.74

### EmOC Training Expenses (Per Batch of 8 trainees):

1.1	Honorarium to Tertiary Centre Faculty (Rs.200 X 8 trainees X 6 weeks of 6 days each)	57600
1.2	Honorarium to District Centre Faculty (Rs.200 X 4 X 10 weeks of all 7 days)	56000
2.1	Lunch and tea for the trainees at medical college (Rs.200 per day per trainee X 8 trainees X 6 weeks X 6 days per week)	57600
2.2	Lunch and tea for the trainees at district hospital (Rs.200 per day per trainee X 8 trainees X 10 weeks X 7 days per week)	112000
3.1	Training material Cost (Rs.250 per candidate x 8 candidates per batch *36 days )	140000
3.2	Training material Cost (Rs.250 per candidate x 8 candidates per batch *70 days )	74000
4.1	DA to the Trainees at Tertiary Care Training Centre (DA @ Rs.700 per day X 36 days X 8 trainees)	201600
4.2	DA to the Trainees at Tertiary Care Training Centre (DA @ Rs.700 per day X 70 days X 8 trainees)	392000
	SUB TOTAL ( At TCTC )	456800
	SUB TOTAL ( At District Hospital)	634000



5.1	Administrative Expenses for State training centres @15%	68520
5.2	Administrative Expenses for District training centres @15%	95100
	TOTAL ( At TCTC ) for one batch of 5 trainees	525320
	TOTAL ( At District Hospital) for one batch of 5 trainees	729100
<b>TOTAL for one batch of 8 trainees</b>		<b>1254420</b>

#### A.11.2.4 Life saving Anaesthesia skills training

To overcome the scarcity of specialist manpower at the public health facility, MBBS doctors are promoted for gaining Anaesthetic Skills in Emergency Obstetric Care and Obstetric Management Skills to conduct the Caesarean Section at the FRU level. Chhattisgarh was first state to start Multi skilling programme. In the previous course of Multiskilling training, total 94 Doctors was trained and sent back to the nominated FRUs. In those 48 doctors undergone under LSAS, while 46 had undergone EmOC. Meanwhile the course was non-functional because it failed to integrate some new guidelines from the Government of India. In the current year, new batch for multi skilling will be started soon after inviting nomination from the phase III FRUs. The expected training load is 47 doctors, that 32 will be in EmOC and 15 will be in LSAS.

One batch of 15 trainees @ 5 trainees per Tertiary Care Training centre (Raipur Medical College, CIMS Bilaspur & Pt. JNM Institute & research centre, Bhilai) will be trained in LSAS. For this a budget of Rs. 2476755 will be required.

#### Budget Estimation of LSAS Training:-

Description Of Training	No. Of Units	No. Of Batches	Cost Per Batch	Total Budget (lakh)
1	2	3	4	=(3*4)
LSAS training at Medical College	15	3	509220	15.28
LSAS Training at District Hospital	15	3	316365	9.49
Sub. Total	15	3	825585	24.77
Expert examiners	1	3	24000	0.72
<b>Total</b>				<b>25.49</b>



**LSAS Training Expenses (Per Batch of 5 trainees):**

1.1	Honorarium to Tertiary Centre Faculty (Rs.200 X 2 X 12 weeks of 6 days each)	28800
1.2	Honorarium to District Centre Faculty (Rs.200 X 4 X 6 weeks of all 7 days)	33600
2.1	Lunch and tea for the trainees at medical college (Rs.200 per day per trainee X 5 trainees X 12 weeks X 6 days per week)	72000
2.2	Lunch and tea for the trainees at district hospital (Rs.200 per day per trainee X 5 trainees X 6 weeks X 7 days per week)	42000
3.1	Training material Cost (Rs.250 per candidate x 5 candidates per batch * 72 days )	90000
3.2	Training material Cost (Rs.250 per candidate x 5 candidates per batch * 42 days )	52500
4.1	DA to the Trainees at Tertiary Care Training Centre (DA @ Rs.700 per day X 72 days X 5 trainees)	252000
4.2	DA to the Trainees at Tertiary Care Training Centre (DA @ Rs.700 per day X 42 days X 5 trainees)	147000
	SUB TOTAL ( At TCTC )	442800
	SUB TOTAL ( At District Hospital)	275100
5.1	Administrative Expenses for State training centres @15%	66420
5.2	Administrative Expenses for District training centres @15%	41265
	TOTAL ( At TCTC ) for one batch of 5 trainees	509220
	TOTAL ( At District Hospital) for one batch of 5 trainees	316365
	<b>TOTAL for one batch of 5 trainees</b>	<b>825585</b>



### A.11.2.5 MTP training

Despite legalising abortion and existence of liberal policies, majority of women still resort to unsafe abortion contributing substantially to maternal mortality & morbidity. This is largely due to lack of awareness about service providers and places of abortion services. A large unmet need for MTP training exists in both the public & private sectors. The goal of training is to provide MTP training to all Medical Officers posted at District Hospitals, CHCs & PHCs. In Chhattisgarh, ..... the number of centres are accredited for providing safe abortion services & ..... no. Of Doctors are trained service providers. At present 1052 Medical Officers are in service, out of which 120 MOs will be trained in 2010-11 as per GOI guidelines. For this, seven district hospitals at Durg, Bilaspur, Raipur Medical College, Bastar/Kanker, Rajnandgaon, Sarguja, and Raigarh where services of Gynaecologists are available will be designated as training centres. A batch of two MOs per training centre will undergo a 15 days training in MTP services at these centres. Three day orientation training cum TOT will be conducted at SIHFW. The budget requirement is as follows.

#### Budget Estimation of Training in MTP Techniques:-

Description Of Training	No. Of Units	No. Of Batches	Cost Per Batch	Total Budget (Lakh)
1	2	3	4	=(3*4)
Training of Trainers In MTP Techniques@ 2 Master Trainers per Training Centre	14	1	75895	0.75
Training In MTP Techniques	120	60 @ 2 trainees per batch	56575	33.95
Total Budget				34.70
Budget Calculation Per Batch for Training in MTP Techniques				
Heads of Expenditure /Batch size	Cost per Batch		Cost For 60 Batches	TOT
DA* (Rate x No. of Days x No. of Participants) (Rs.700 x 15 x no. of participants)	21000		1260000	29400
Honorarium (In House Faculty) (Rate x Days of training x no. of trainers) (Rs.200 x 15 x No of trainers)**	6000		360000	9000



Incidental Exp. like study material , course material, Photo copying, job aids, flip charts, LCD etc. (Rate x Days of training x no. of trainees) (Rs.250 x 15 x no. of trainees)	7500	450000	10500
Working Lunch, Tea & Snacks (Rate x Days of training x no. of trainees) (Rs.200 x 15 x no. of trainees)	6000	360000	8400
Sub Total	40500	2430000	57300
IOH @15% of Sub Total	6075	364500	8595
Total	46575	2794500	65895
Venue Hiring Charges	10000	600000	10000
TA	From State Govt. budget as per norms	3394500	75895

#### **A.11.2.6 RTI / STI Training**

The training will be conducted by the Chhattisgarh State AIDS control Society.

#### **A.11.2.7 Other MH Training (ISD Refresher): Staff Nurse Induction Training**

Almost half of the births in developing countries take place without a skilled service provider. Every minute of every day, somewhere in the world a woman dies. The single most important intervention for safe motherhood is to ensure that trained provider is present at every birth. The state has recruited 213 staff nurses on contract basis under NRHM during 2009-10 & plans to recruit 200 more in year 2010-11. These nurses are specifically posted at PHCs to provide obstetric care services to all mothers. To achieve this, the state plans to provide 10 days hands on training at District Hospital or CHC to newly appointed staff nurses. This training will include topics as introduction to NRHM, skill based training in maternal & child health, waste management and infection prevention, adolescent health & emergency duties. District & Block level trainers including Medical Officers & Program Managers already trained under various individual programs will execute this training. Approx. The batch size will be 5 trainees per batch and approx. 400 Staff Nurses (210 Old + 190 New) will be trained this year.



### Budget estimation:-

Description Of Training	No. of Units	No. of Batches	Cost Per Batch	Total Budget (Lakh)
1	2	3	4	=(3*4)
Induction Training Of Newly Appointed Staff Nurses	400	80	65775	52.62

### Budget Calculation for Staff Nurse Induction Training

No. of participants per batch =5	No. of trainers = 3	No. of training days = 10 days
<b>Heads of Expenditure /Batch size</b>	<b>Cost per Batch</b>	<b>Cost For 80 Batches</b>
DA* (Rate x No. of Days x No. of Participants) (Rs.700 x 10 days x 5 no. of participants)	20000	1600000
Honorarium (In House Faculty) (Rate x Days of training x no. of trainers) (Rs.200 x 10 days x 3 No of trainers )**	6000	480000
Incidental Exp. like study material , course material, Photo copying, job aids, flip charts, LCD etc. (Rate x Days of training x no. of trainees) (Rs.250 x 10 x 5 no. of trainees)	12500	1000000
Working Lunch, Tea & Snacks (Rate x Days of training x no. of trainees) (Rs.200 x 10 x no. of trainees)	10000	800000
Sub Total	48500	3880000
IOH @15% of Sub Total	7275	582000
Total	55775	4462000
Venue Hiring Charges	10000	800000
TA	From State Govt. budget as per norms	From State Govt. budget as per norms
<b>Total</b>	<b>65775</b>	<b>52.62000</b>



#### A.11.4

#### IMEP Training

##### Issues and Challenges

The major issues and challenges relevant to health and environmental risks in healthcare

Facilities are as follows:

**Treatment and disposal of bio-medical waste:** - Currently many healthcare facilities are not managing their infectious waste in accordance with the Bio-Medical Rules promulgated by the Government of India. The challenge is to get all levels of healthcare facilities to institutionalize proper infection control measures and sound treatment and disposal of Bio-medical wastes.

**Disposal of sharps:** Disposal of sharps is a big issue in the rural areas and at primary healthcare facilities. Studies revealed that a very large proportion of injections administered in the country are unsafe and syringe disposal techniques are faulty throughout the country.

Institutionalizing good practices in this regard is one of the challenges.

**Auto Disable (AD) plastic syringe wastes:** Under the RCH-II programme, we are using AD syringes for routine immunisation. There is expected to be a large quantity of plastic waste that will need to be disposed off in an environmentally sound manner. Proper treatment and disposal of these wastes will be another challenge.

**Water and sanitation:** In primary level health facilities, provision of clean, potable and continuous water supply is a documented issue. Associated with it, the treatment and disposal of waste water and sewage and continued operation and maintenance systems needs to be addressed.

**Design and construction-related issues:** Under NRHM new constructions, such as sub-centres, operation theatres, labour rooms, new-born care corners and blood storage facilities are initiated & many are installing diesel generation sets. All these will require proper designing and will also result in the generation of construction waste, which needs to be disposed in an environmentally responsible manner.

**Information, skill and attitude:** Lack of information, awareness and skills is one of the primary factors for poor implementation of infection control and bio-medical waste management. The challenge is to provide healthcare workers with skills training, protective equipment and appropriate tools to bring about a fundamental shift in their mindset and behavioural pattern.

##### Activity -

The state plans to give training to healthcare workers and officers in IMEP implementation in a phase wise manner. There will be two types of training schedules – (i) A group of Trainers



at State & District level and (ii) regular on-going training of staff within the health facilities. The duration of this training is one day training & state & district level TOT will be conducted to disseminate infection management training to selected peripheral units. The budget of Rs. 16,60,000 is proposed for IMEP training of 1500 staff this year.

#### Budget estimation:-

Description of Training	Venue	Training Load	Per unit cost of Training	Total (lakh)
1	2	3	4	=(3*4)
State Level TOT@ ( five Medical Officers & Program managers/Hospital Consultants )	Delhi	5	20000	1.00
District Level TOT ( One MO and One Hospital Management Consultant )	Raipur	36	1400	5.04
Peripheral Level training of selected FRUs blocks*	Each district HQ	1500	1000	15.00
Total Cost				21.04
*At peripheral level one Medical Officer, RMA, Staff Nurse and all ANMs will be trained by District level Trainers.				

#### A.11.5 Child Health Training

##### A.11.5.1 IMNCI: Facility based - Integrated Management of Neonatal and Childhood Illnesses

75 percent of infant deaths occur in neonates in Chhattisgarh (SRS 2007). Now, as institutional deliveries are increasing due to Janani Suraksha Yojana, we have increasing newborns who are taking birth in health institutions. Training of Medical Officers in IMNCI has been initiated in three districts since one year through the RCH Capacity Building Unit of SIHFW which is established with support from UNICEF. This year, the newly GOI approved FIMNCI package of 11 days training will be used. Personnel only from the facilities that are conducting institutional deliveries will be trained in FIMNCI coordinated through the RCH Capacity Building Unit of SIHFW. These training will be organised in close collaboration with 1) Pt. J N M Medical College, Raipur, 2) Bastar Medical College and 3) Bilaspur Medical College. In the state the Paediatrics Dept of Pt J N M Medical College will synchronise training of Medical Officers and Dept of PSM of Pt J N M Medical College will coordinate training of ANMs.



This year, under FIMNCI trainings, 366 Medical Officers from all districts will be trained. For this all Medical Officers from HBNC blocks will be trained along with two MOs from each CHC (i.e. total 164 health institutions). This is an 11 days training and priority will be given to those facilities where regular institutional deliveries are taking place. Printed recording forms will be given to these institutions to record the sickness. Also flex boards depicting standard treatment guidelines (10 in number for each institution as per FIMNCI standards) will be given to each health institute.

#### Budget Estimation:-

Description Of Training	No. Of Units	No. Of Batches	Cost Per Batch	Total Budget (lakh)
1	2	3	4	=(3*4)
FIMNCI Training to Medical officers	336	21	252880	53.11
Total Budget				53.11

FIMNCI Training		
Heads of Expenditure /Batch size	Cost per Batch	Cost for 21 Batches
DA* (Rate x No. of Days x No. of Participants) (Rs.700 x 11 days x 16 no. of participants)	123200	2587200
Honorarium (In House Faculty) (Rate x Days of training x no. of trainers) (Rs.200 x 11 x 4No of trainers)**	8800	184800
Incidental Exp. like study material , course material, Photo copying, job aids, flip charts, LCD etc. (Rate x Days of training x no. of trainees) (Rs.250 x 12 x 5 no. of trainees)	44000	924000
Working Lunch, Tea & Snacks (Rate x Days of training x no. of trainees) (Rs.200 x 12x 5 no. of trainees)	35200	739200
Sub Total	211200	4435200
IOH @15% of Sub Total	31680	665280



Total	242880	5100480
Venue Hiring Charges	10000	210000
TA	From State Govt. budget as per Norms	From State Govt. budget as per Norms
Total	252880	5310480

#### A.11.5.2 Facility Based Newborn Care

Training of medical staff and para – medicals will be done by UNICEF with their resources – which are not budgeted in this PIP.

#### A.11.5.3 Home Based Newborn Care

Kindly refer to activity no. A.2.3 (Pg no. ....)

#### A.11.5.5 Training under Navajati Sishu Suraksha Karyakram

The trainings for NSSK have been recently started in the State and two batches of two days training each with IAP support has been conducted in December 2009. In 2010 – 11, the training will be conducted for personnel of health institutions that are conducting institutional deliveries. Thus in Chhattisgarh, out of 721 PHCs – 354 are conducting deliveries, out of 146 CHCs and 18 district hospitals- all are conducting deliveries and out of 4776 sub centres – 999 are accredited for conducting deliveries. For PHCs, four health staff – one each of Medical Officer, Rural Medical Assistant, Staff Nurse and LHV will be trained. For CHCs, five health staff – two Medical Officers, one Rural Medical Assistant and two Staff Nurses will be trained. For sub centre, one ANM will be trained. For District Hospital seven health staff – two Medical Officers and five Staff Nurses will be trained. Thus a total of 3241 health staff will be trained for two days at the district level. Thus there will be 81 batches year. The RCH capacity building unit in SIHFW will be coordinating these trainings along with IAP at the district level.

#### Budget estimation:-

Description Of Training	No. Of Units	No. Of Batches	Cost Per Batch	Total Budget (lakh)
1	2	3	4	=(3*4)
NSSK Training to Medical Officers	678	17	117640	20.00
NSSK Trainings to RMAs + Staff Nurse + LHV +	2563	64	90040	57.63



ANMs			
Total Budget	81		77.63

**Navajati Sishu Suraksha Karyakram**

Heads of Expenditure /Batch size	Cost per Batch for Medical Officers	Cost For 17 Batches	Cost per Batch for SN/ANM/LHVs	Cost For 64 Batches
DA* (Rate x No. of Days x No. of Participants) (Rs.700/400 x 2 days x 40 no. of participants)	56000	952000	32000	2048000
Honorarium (In House Faculty) (Rate x Days of training x no. of trainers) (Rs.200 x 2 x 4 No of trainers)**	1600	27200	1600	102400
Incidental Exp. like study material , course material, Photo copying, job aids, flip charts, LCD etc. (Rate x Days of training x no. of trainees) (Rs.250 x 2 days x 40 no. of trainees)	20000	340000	20000	1280000
Working Lunch, Tea & Snacks (Rate x Days of training x no. of trainees) (Rs.200 x 2 days x 40 no. of trainees)	16000	272000	16000	1024000
Sub Total	93600	1591200	69600	4454400
IOH @15% of Sub Total	14040	238680	10440	668160
Total	107640	1829880	80040	5122560
Venue Hiring Charges	10000	170000	10000	640000
TA	From State Govt. budget as per Norms	1999880	From State Govt. budget as per Norms	5762560
Cost Of one batch	117640		90040	



## A.11.6 Family Planning Training

### A.11.6.1 Laparoscopic Sterilisation Training

A total of 40 Gynaecologists & Surgeons will be trained in LTT operation techniques at State Family Planning Training Centre, District Hospital Bilaspur. In the year 2009 -10, seven gynaecologists have been trained in LTT sterilization technique.

#### Budget estimation:-

Description Of Training	No. Of Units	Duration of training	No. Of Batches	Cost Per Batch	Total Budget (lakh)
1	2	3	4	5	=(4*5)
LTT training	40	12 working days	8	100390	8.03

### A.11.6.2 Minilap Training

A total of 50 Medical Officers will be trained in Conventional Tubectomy operation techniques (Minilap) at State Family Planning Training Centre -District Hospital Bilaspur. In the year 2009 -10, ten Medical Officers have been trained in LTT sterilisation technique.

#### Budget estimation:-

Description Of Training	No. Of Units	Duration of training	No. Of Batches	Cost Per Batch	Total Budget (lakh)
1	2	3	4	5	=(4*5)
LTT training	50	12 working days	10	100390	10.04

#### Cost Calculation of training in LTT/CTT techniques

Heads of Expenditure /Batch size	Cost per Batch	Cost for 8 Batches
DA* (Rate x No. of Days x No. of Participants) (Rs.700 x 12 days x 5 participants)	42000	336000



Honorarium (In House Faculty) (Rate x Days of training x no. of trainers) (Rs.200 x 12 x 4 trainers )**	9600	76800
Incidental Exp. like study material , course material, Photo copying, job aids, flip charts, LCD etc. (Rate x Days of training x no. of trainees) (Rs.250 x 12 x 5 trainees)	15000	120000
Working Lunch, Tea & Snacks (Rate x Days of training x no. of trainees) (Rs.200 x 12x 5 trainees)	12000	96000
Sub Total	78600	628800
IOH @15% of Sub Total	11790	94320
Total	90390	723120
Venue Hiring Charges	10000	80000
TA	From State Govt. Budget as per norms	From State Govt. Budget as per norms
Total	100390	803120

### A.11.6.3 NSV Training

A total of 40 Medical Officers will be trained in NSVT operation techniques at State Family Planning Training Centre - District Hospital Bilaspur. In the year 2009 -10, twelve Medical officers have been trained in NSV sterilisation technique.

#### Budget estimation:-

Description Of Training	No. Of Units	Duration of training	No. Of Batches	Cost Per Batch	Total Budget (lakh)
1	2	3	4	5	=(4*5)
NSVT training	40	5 working days	8	47663	3.81



<b>Budget calculation for Training in NSV Technique</b>		
<b>Heads of Expenditure /Batch size</b>	<b>Cost per Batch</b>	<b>Cost for 8 Batches</b>
DA* (Rate x No. of Days x No. of Participants) (Rs.700 x 5 x 5 no. of participants)	17500	140000
Honorarium (In House Faculty) (Rate x Days of training x no. of trainers) (Rs.200 x 5 x 4No of trainers )**	4000	32000
Incidental Exp. like study material , course material, Photo copying, job aids, flip charts, LCD etc. (Rate x Days of training x no. of trainees) (Rs.250 x 5 x 5 no. of trainees)	6250	50000
Working Lunch, Tea & Snacks (Rate x Days of training x no. of trainees) (Rs.200 x 5 x 5 no. of trainees)	5000	40000
Sub Total	32750	262000
IOH @15% of Sub Total	4913	39300
Total	37663	301300
Venue Hiring Charges	10000	80000
TA	From State Govt. budget as per Norms	From State Govt. budget as per Norms
Total	47663	381300

#### **A.11.6.4 IUD Insertion Training**

The acceptance of Intra Uterine Contraceptive Device (IUCD) is lower than other contraceptives methods at 0.6% as compare to 47.1% acceptance by any modern method (DLHS-III). One of the reasons attributed to this low usage is lack of proper insertion skills of the service providers. The presence of skilled service providers is helpful in providing quality contraceptive services thereby contributing to lower down the unmet needs of population. In the year 2009-10, the training of 400 health workers of Raipur district is complete and tentatively the number of ANMs, SNs & LHVs from other 16 districts trained in IUCD insertion



by March 2010 will be 200. We have budget for training another 1548 workers in year 2010-11. The state plans to train total 1748 workers by March 2011, for which a budget of Rs.1, 19,78, 000 has already been released to districts. So no budget will be required for conducting this activity in 2010-11. The training of rest service providers will be budgeted in year 2011-12.

### A.11.8 Programme Management Training

#### A.11.8.1 SPMU Training

This year separate budget is sought for providing trainings to PMU staff at State, district & block level. These skill up gradation & career development trainings will be on various public health management, data and finance management related topics, depending upon the requirement, work output, subject & interest of the trainees.

Description Of Training	No. Of Units	Duration of training	Cost Per Head	Total Budget (lakh)
1	2	3	4	=(2*4)
Management trainings to SPMU staff	20	As per training program	40000	8.00
TOTAL				8.00

#### A.11.8.2 DPMU & BPMU Training

Description Of Training	No. Of Units	Duration of training	Cost Per Head	Total Budget (lakh)
1	2	3	4	=(2*4)
Management trainings to DPMU staff	54	As per training program	20000	10.80
Management Trainings to BPMU staff	146	As per training program	3500	5.11
TOTAL				15.91



### A.11.9 Other training

### A.12 BCC / IEC: Proposed Activities and Budget

**Introduction:** In order to sustain programmatic interventions and create awareness for prevention of health problems, it is planned to undertake an innovative and comprehensive approach to IEC and BCC activities that would result in the achievement of NRHM objectives. Generally, IEC and BCC activities are not given their due importance within health programmes and instead, the hardware aspects are usually emphasized. However, it has been recognized by Review Missions and several studies on health sector interventions that awareness generation, knowledge creation that results in intention and adoption of healthy practices (behaviour) can have a far-reaching impact on the health standards of communities. This proposal seeks to strengthen this aspect within the NRHM implementation strategy so as to ensure sustainability and a positive environment for communities to adopt positive behaviours.

**Problems and issues:** The key issues facing Chhattisgarh State that impede the implementation of IEC and BCC activities include:

- **Human resource deficiencies:** There are three aspects to this major problem which confronts the state. First, there is a shortage of staff deployed within the state, district and block levels. For instance, only six District Media Officers are deployed out of 18 vacancies (18 Districts of Chhattisgarh). There are just 60 Block Extension Educators in a state which has 146 blocks. Further, the staff at all levels are poorly trained and placed in tasks that do not pertain to their core functions. And most importantly, the staff is not provided recognition for their mandated roles; they are often lack motivation and interest in their core jobs.
- **Institutional gaps:** There is no formalized IEC Bureau within the state. Currently, the IEC activities at the state-level are led by the Director, Family Welfare and supported by the Deputy Director (IEC, Family Welfare, Immunization, RCH) and two Block Extension Educators placed at the state-level to manage and implement activities. Technical specialists and Programme Officers directly implement IEC and BCC activities without strategic understanding, despite the technically competent human resources that are available at state, district and block levels. **Regional diversity:** The socio-cultural canvas of Chhattisgarh is divided in three distinct eco-cultural zones. The north being tribal, mountainous and thickly forested. The rice plains of the centre are largely dominated by OBC communities and have sparse forest tracts, and highly industrialized. The south comprises of tribes (some primitive), large, dense and sparsely populated regions, thick forests and problems arising from Naxalism. These are the most media dark areas of the state.



**Addressing the challenges:** Lack of community awareness: Several Knowledge, Attitude and Practice (KAP) studies have clearly demonstrated the poor awareness amongst communities on positive health behaviour practices. For instance, despite high female literacy rates in Rajnandgaon district (77 per cent), the exclusive breastfeeding rates are lower than the state average and currently stand at just over 46 per cent. Similarly, institutional deliveries currently stand at about 30 per cent with an urban skew. The situation in rural areas is compounded with poor state of facilities that deter beneficiaries from utilizing institutional services. Malaria is the second biggest cause of the high maternal mortality rate prevalent in the state. Despite this, only 2.1 per cent households utilize mosquito nets or other ways to prevent mosquito bites (CES 2006; UNICEF and Government of India)

**Lack of structured communication plan, resources and tools:** Given the low priority accorded to IEC and BCC activities in the state, there is no effort made to develop a structured communication plan. Given this situation, regional consultation workshops were organized to understand the needs of particular areas and technical resources that would strengthen IEC and BCC interventions. The following chart describes the needs assessment which emerged from the regional consultations:

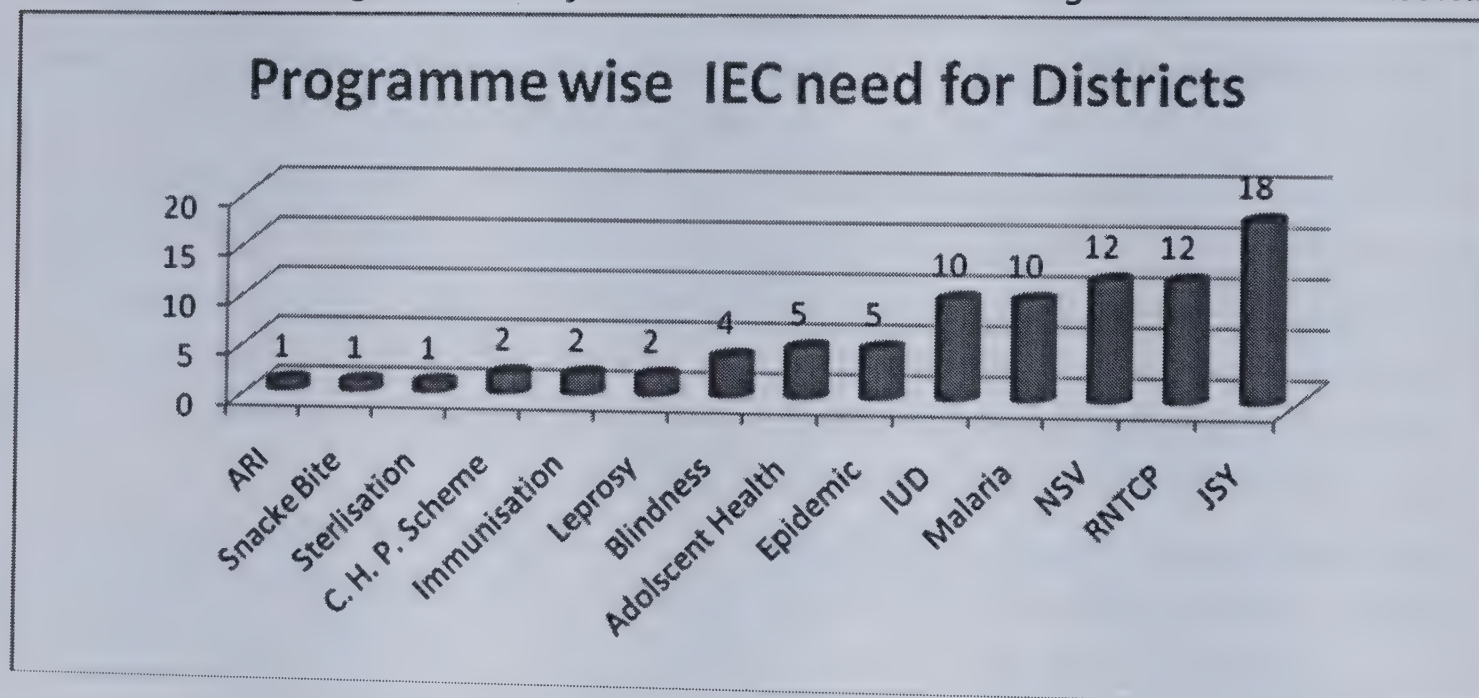


Chart displays needs assesment from 18 districts, compiled based upon key programmtic interventions

Simmilarly the activities which were discussed and prioritizd by IEC and other relevant field staff at regional levels are consolidated in the chart provided below:



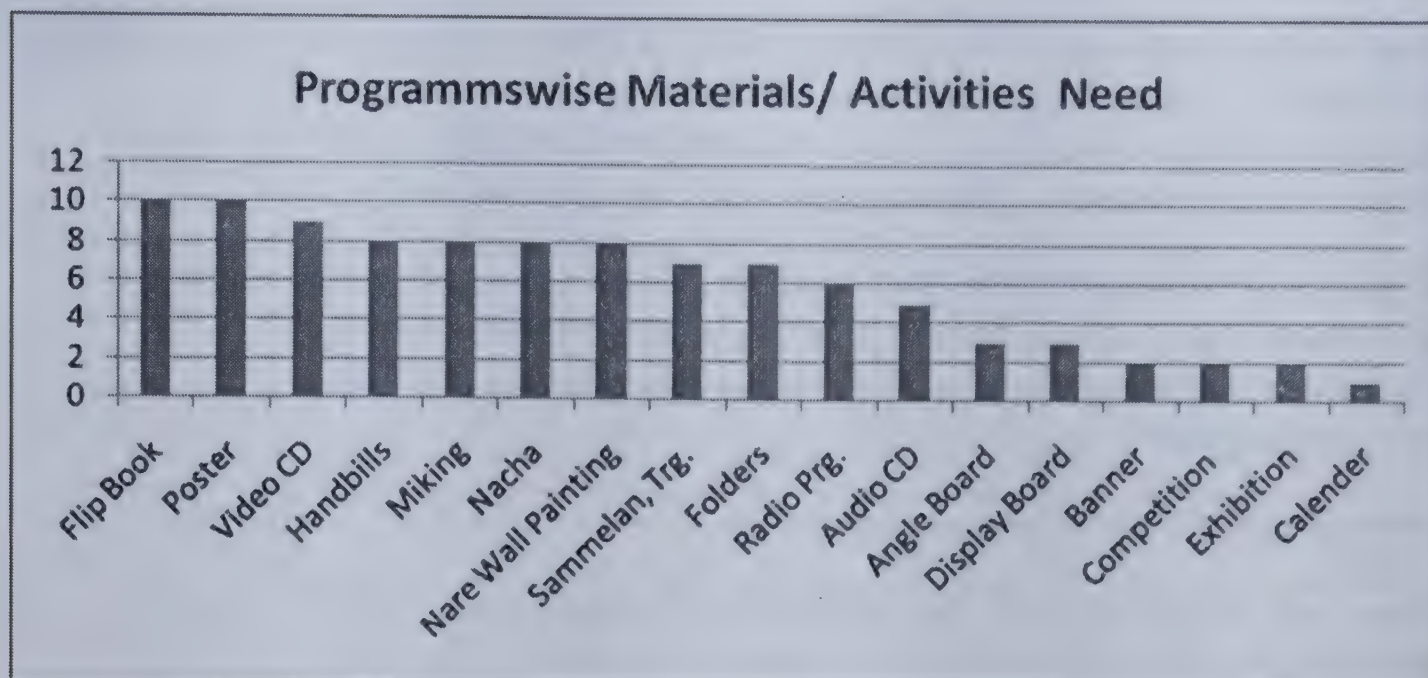


Chart displays resource requirements from regional **consultaions** that are addressed in this planning cycle

Need for participatory planning, implementation, monitoring and evaluation: Currently, most IEC activties are developed through a top-down aproach with limited opportunities provided to implementors for their inputs in the design of initiatives. It is envisaged that during this implementation cycle of the NRHM, views of key stakeholders shall be taken on board and a bottom-up process shall be adopted to ensure relevance of materials and approach. In addition, assistance shall be sought from UNICEF to undertake impact studies of IEC and BCC activties and promote learning for greater efficacy.

#### Summary Implementation plan and budget:

Detailed activities	Proposed budget (Rs. lakhs)
<b>Establishment of IEC/BCC unit at state and district levels:</b> It is proposed to strenghten the state-level machinery with human resources, including one Graphics Designer with salary drwan from SPMU. The proposed approach seeks to utilize current resources in an effective manner instead of adding more staff at this sage. This is to ensure effectiveness of current staff deployed as well as to demosntrate the efficacy of programmtic approaches. This is therefore an approach to consolidate existing interventions. During subsequent planning cycles, the pool of human resources shall be enhanced to match the programme load. Given that the SPMU has already proposed an IEC Consultant at the state-level, no further strenghtening is envisaged at this stage. At the district and blocks, it is proposed to utilize the strenghts of existing functionaries posted through regular NRHM funds.	Budget for human resources allocated from SPMU/NRHM



<b>Formative Research and development of IEC/BCC strategy:</b> Regional consultations were undertaken to determine priorities and programmatic interventions mix. This is reflected in the earlier section. Hence, no further research of strategy development is proposed	NIL
<b>Interpersonal Communication</b> (Skill building, Resources including flip books, folders etc., Group Meetings for Panchayat Representatives and Women's Groups, Training of frontline functionaries including Anganwadi Workers)	66.50
<b>Community Media</b> for awareness generation	23.00
<b>Narrow and Mass Media</b> including State and District-level events, exhibitions, TV spots, radio jingles and signage, posters, hoardings as well as wall writing, slogans	58.50
<b>Total</b>	<b>148.00</b>

A detailed presentation of the budget is annexed with this proposal and contains programme-wise allocations (see annexure-I)

#### Conclusion:

This proposal reflects the need to create an enabling environment for Behaviour Change. It recognizes that awareness generation alone does not result in adoption of positive behaviours. Hence, an attempt is made to complement existing programmatic interventions so that sustainability is achieved over the programme cycle. The approach seeks to consolidate the available resources, skills and experience to optimize their utilization. During subsequent planning cycles, an effort shall be made to learn lessons from the experience of the state and expand the outreach of IEC activities aimed at behaviour change.



## Annexure-I Detailed and programme-wise budget presentation

Programme wise Proposed IEC/BCC Activities and Budget for Year 2010-11										
Media	S.N.	Activities	Maternal Health	Janani Suraksha Yojana	Child Health	Adolescent Health	IUCD	NSV	Other Activity	Total Part A
IPC	1	Flip Books / Booklet for Health Workers/Students	4.00		2.00	10.00	2.00	2.00		20.00
	2	Folders/ Handbills for PRIs Sammelans and MPWs for IPC	5.00	2.00	2.00		1.00	1.00		11.00
	3	4. PRI Sammelans Block /PHC level	5.00		5.00			5.00		15.00
	4	4. Mahila Panch Sammelans Block Level					7.00			7.00
	7	One day IPC Training of MPWs ,Supervisors, AWWs, Mitanin	4.50		4.50		4.50			13.50



		<b>Sub TOTAL</b>	<b>18.50</b>	<b>2.00</b>	<b>13.50</b>	<b>10.00</b>	<b>14.50</b>	<b>8.00</b>	<b>66.50</b>
<b>Community Media</b>	<b>1</b>	Traditional Nacha / Six per Block		7.00				7.00	14.00
	<b>2</b>	3. Milking for Campaign	2.00					7.00	9.00
		<b>Sub TOTAL</b>	<b>2.00</b>	<b>7.00</b>				<b>14.00</b>	<b>23.00</b>
<b>Mass and Narrow Media</b>	<b>1</b>	Hoardings		5.00					5.00
	<b>2</b>	Flex/ Posters for Health Institution, AWW centres, Panchayats etc.	2.00				0.50	7.50	10.00
	<b>3</b>	6. Stickers for Public Vehicles (Bus, Autos, etc.)		1.00					1.00
	<b>5</b>	4. Wall Paintings, 2 per PHC/CHC Village		1.00			2.50	2.50	6.00
	<b>3</b>	7. Video Spot and Jingles Advt. in Video Albums and Audio Songs / News articles / Production		2.00				2.00	4.00
<b>4</b>		10. Video Spot/ Scroll Tele cost in Local Channels	5.00					8.00	13.00





	<b>5</b>	<b>9. Radio jingles Tele cost in Radio and FM</b>								<b>3.00</b>		<b>3.00</b>
	<b>6</b>	<b>3. Display / Scroll Board for DH/CHC/PHC</b>								<b>2.00</b>		<b>2.00</b>
	<b>11</b>	<b>State Activities :- Janki, Exhibition, And Advt. Workshop .etc-</b>									<b>10.00</b>	<b>10.00</b>
	<b>12</b>	<b>Dist. Activities :- Janki, Exhibition, And Advt. Workshop .etc-</b>									<b>4.50</b>	<b>4.50</b>
		<b>Sub Total</b>	<b>7.00</b>	<b>9.00</b>	<b>0.00</b>	<b>0.00</b>	<b>0.00</b>	<b>0.00</b>	<b>5.00</b>	<b>23.00</b>	<b>14.50</b>	<b>58.50</b>
		<b>Grand Total</b>	<b>27.50</b>	<b>18.00</b>	<b>13.50</b>	<b>10.00</b>	<b>19.50</b>	<b>45.00</b>	<b>14.50</b>	<b>148.00</b>		
	Part A	Maternal Health	45.50	<b>148.00</b>								
	Part A	Child Health	13.50									
	Part A	Adolescent Health	10.00									
	Part A	Family Planning	64.50									
	Part A	Other activities	14.50									
		<b>Total</b>	<b>148.00</b>									



## A.14 PROGRAMME MANAGEMENT

There is also a special focus on improving financial management with provision of Tally Software till block level PMUs & appointment of auditors for monthly concurrent audit of all sub societies. The plan for 2010-11 is to initiate & execute monthly concurrent audit till block level. At the state directorate and NRHM PMU level, the proposal is for 21 consultants as against 12 consultants who are functional today. Further, there is a proposal for continuing the district PMUs as already are in place. An addition to the district PMU has been the placement of Hospital Consultants within the PMU to accelerate the convergence between District Hospital & District health administration. The block PMU has also been established at 75 blocks with the provision of one Block Program Manager & Block Accounts & data assistants to facilitate the block level administration in planning & implementation of health programs. Another addition to Programme is recruitment of PHC level accounts The state plans to recruit all the vacant positions by March 2010. Another addition is the recruitment & positioning of one accounts & data assistant at all 716 Primary Health Centres to help manage NRHM funds & activities.

### Budget Estimation for Program Management Unit:-

S no	Unit Description	Unit cost	No. of Units	Duration	Total Cost
A	Strengthening State PMU & NRHM Secretariat				
1	State Programme Manager	47300	1	12	567600
2	State Maternal/ Child Health Officer	34500	1	12	414000
3	State BCC/ IEC Officer	25300	1	12	303600
4	State Human Resource Officer	25300	1	12	303600
5	State Procurement Officer	25300	1	12	303600
6	State Demography Officer (April 10 - Nov. 10)	25300	1	12	303600
7	State Training Officer	34200	1	12	410400
8	State HMIS Officer	34200	1	12	410400
9	State Monitoring/ Evaluation Officer	34200	1	12	410400
10	State Finance Manager	40500	1	12	486000
11	State Accounts Manager	34200	1	12	410400
12	State Data Officer ( April 10 -Nov 10)	23000	1	12	276000
13	Accountant	11000	4	12	528000



14	State Data Assistant (Immunization)	12000	1	12	144000
15	Office Assistant ( Already Working)	12500	4	12	600000
16	Data Entry Operator ( Already Working)	9500	8	12	912000
<b>B</b>	<b>Strengthening District PMU</b>				
1	District Programme Manager (Already Working)	37000	16	12	7104000
2	District Programme Manager	28800	2	12	691200
3	District Accounts Manager	27000	12	12	3888000
4	District Accounts Manager	21000	6	12	1512000
5	District Data Officer	24000	14	12	4032000
6	District Data Officer	18400	4	12	883200
7	Hospital Consultant	26000	17	12	5304000
8	Account Assistant	11000	18	12	2376000
9	Data Assistant	11000	18	12	2376000
<b>C</b>	<b>Strengthening Block PMU</b>				
1	Block Programme Manager	18000	146	12	31536000
3	Block Account cum Data Assistant	15000	146	12	26280000
6	Account and data assistant (PHC level)	6000	350	12	25200000
<b>Total (A+B+C)</b>					<b>1179.66 lakh</b>



## B TIME LINE ACTIVITIES - Additionalities under NRHM (Mission Flexible Pool)

### B1 ASHA / Mitanin

At the end of 2009-10, the Mitanin programme is almost completing its 7 years. It is having clear impact on breast feeding practices, institutional delivery, decreasing IMR, first contact curative care, referral management etc. 13<sup>th</sup> round of the Mitanin training will be completed by end of current year and the TOT for 14<sup>th</sup> round will be ongoing. In current year training was mainly accomplished on 13<sup>th</sup> round of the Mitanin training will be completed by end of current year and the TOT for 14<sup>th</sup> round will be ongoing. In current year training was mainly accomplished on

- IMNCI based 10<sup>th</sup> round of training – second round three day in 55 blocks.
- 11<sup>th</sup> round of training on Village health Planning (VHSC) and strengthening in 28 blocks.
- IYCF and counselling based 12th round training in 113 blocks.
- 13th round of training on Behaviour Change Communication in one block.

In state currently 59489 Mitanins are actively working as Community Health Volunteers (ASHA), but state is receiving fund as per 29000 ASHAs (as 29000 AWWs were working in state). Currently 35000 AWWs are working in state, so state need fund as per the 35000 AWWs numbers to organize 59489 Mitanins.

**The current year Mitanin training status (till Dec 09) is as per follows**

Rounds of Training	Mitanin Training Status
AYUSH based 9th round of training	1069 ( total=55304)
IMNCI based 10th round of training-first round 5 day	62( total=57551)
IMNCI based 10th round of training-Second round 3 day	32081(total=53665)
11th round of training on Village health Planning(VHP)	50229
12 <sup>th</sup> round of training on IYCF	44339
13th round training on BCC.	Training of STT (29)
	Training of DRP (388)
	Training of MT (2920)
	Training of Mitanin(240)



***Along with above training the other key activities done under Mitadin Programme are***

- ***Strengthening of VHSC through Mitadin cascade;*** the Mitadin has been leading VHSCs as convenor. 18550 Mitadins as convenor led the strengthening process of VHSCs and facilitated use of its untied fund in different social, sanitation related actions.

***Following are some example for which Mitadins convener facilitated use of untied fund***



1. Hand pump cleaning,
2. Drainage cleaning,
3. drainage construction,
4. bed net purchase,
5. purchase of children weighing machine,
6. purchase of adult weighing machine,
8. Tube well repair,
9. Information board,
10. Pond cleaning,
11. Treatment of poor,
12. transportation for institutional delivery,
13. Kerosene spray,
14. Incentive to TBA for active work, members,
15. Pouring lime to ponds,
16. drum purchase,
17. Chair purchase,
18. Delivery table construction,
19. Sitting platform construction,
20. Murram filling,
21. Epidemic information mobility,
22. Soak pit construction,
23. Well cleaning,
24. Tank construction,
25. platform for boring construction,
26. Tree cutting,
27. Purchase of DARI
28. help to Prerna Dal (local folk Media)
29. Purchase of different register/files/stationary for VHSCs,
30. banner for Malaria Yatra/Polio program,
31. wall slogan writing,
32. Pond GHAT cleaning,
33. Cutting of Gajar Grass,
34. Construction of boundary of well,

35. treatment for malnourish children,
36. Construction of garbage pit,
37. Filling of pit,
38. Treatment of diarrhoea,
39. Purchase of casing pipe for boring,
40. labour payment in different work,
41. Purchase of child cradle,
42. Alley cleaning, and
43. financial support for cremation,
44. Opening bank account,
45. Emergency support,
46. Support for delivery.
47. Initiating village health planning (till now initiated in more than 1000,
49. Treatment of adolescent
50. God Bharai
51. for organizing health rally in village
53. Hand pump repairing,
54. Rally for Sishu Sanrakshaan Month,
55. Purchase of disposable syringe,
55. Item like Table, Dari for SHC,
56. Construction of pipe in drainage system,
57. Construction of SNANGRIH (bath room),
58. Purchase of medicine for Mitadin Drug Kit,
59. Information board for VHSC
60. Mitadin Name Plate,
61. Financial support in girl marriage,
62. Financial help to TB patient,
63. Incentive to Mitadin for active work,
64. Contribution as SHRUMDAM,
65. Showing film,
66. Building for VHSC etc.



- Generally, Mitanins participated in all Village Health and Nutrition Day every month.
- The BCC kit for Mitanins has been provided to all Mitanin Trainers and District Resource Persons. The BCC kit contain one book on local food, five flipbook on key messages, a set of flash cards, a decision chart and a set of three films are being given to improve the quality of family counselling.
- A database of Mitanins and trainers compiled on their social background and it will be completed by March 2010. The information was instrumental in screening of Mitanins for ANM/BSc nursing courses.
- Since April 09 all Mitanins are monitoring the Infant death at hamlet level across state, facilitating discussion on that in VHSC meeting. Till now more than 2000 death format has been collected at state level (till Sep 09) and 655 infant deaths are analysed.

#### **Infant death from April 09 to Sept 09 across state**

- Identification of problems at hamlet level under NREGA, MDM, JSY program and it is being addressed at different levels for solution.

Total death	1 <sup>st</sup> day	1 <sup>st</sup> week	1 <sup>st</sup> month	2 to 12 month
655	193	245	94	123

To equip Mitanins at the hamlet level to provide first contact curative care on time, provision of Mukhya Mantri Dawa Peti has been made. Refilling of drugs in Dawa Peti takes place once in every two months. Previously the procurement and logistics was done by the District Health Society (DHS). In current year, the procurement and logistics has been done at the state level and distributed (through CMHOs and BMOs). Irregular supply of drugs emerged as a problem in all districts. Regular supply of drugs needs to be done to provide first contact curative care on time. State has taken decision to solve this by taking support of SHRC, and a mechanism has been devised to transport drug from state to blocks directly. Since May 09 to Jan 10 the supply to all 60000 hamlets is regular this year.



- *The process of listing of hamlets without Mitans in state is being undertaken.*
- *More than 300 Mitans has been short listed for ANM course IN private ANM college (process is ongoing, priority has been given to hardest/harder CHC/PHC under CGRMC).*
- *35 Mitans has been given opportunity to do 4 year B.SC (nursing) from seven private nursing colleges and more than 300 Mitans has been short listed for ANM course from private colleges ( process is ongoing ).*
- *Mitanin Help Desk at CHCs level and at the district hospitals are made functional this year.*



**The incentives to Mitanins under different heading – The current status of Incentives provided to Mitanins under various schemes**

S. No	Incentive purpose	Compensation (In Rs.)/per case	Estimated case/work load per Mitanin per annum	Yearly state target	Budget	Current Status
1	JSY	200+150	5 case	300000	Part A- section .....	All Mitanins are regularly receiving the incentives as per the guideline. The problem faced under this is mainly due to unavailability of the fund.
2	Immunisation session	50	12	720000	Part C section .....	All Mitanins are regularly receiving the incentives every month as per the guideline. Problem faced in few districts was due to ambiguity in the guideline.
3	Family Planning	150/200	2	120000	Part A section .....	All Mitanins are receiving the incentives as per the number of motivated cases referred by them. The problem faced was due to the revised guideline of GOI in which the incentive eligibility spreads over the wide range of motivators in



								place of ASHA. This required to be worked out for CG.
4	RNTCP-DOTS	250	0.3	18000	Part section.....	D	Hardly 2% (i.e. 1200 to 1300) Mitans are DOTS provider. The non availability of fund is also emerged as a problem. Special attention is required for this.	
5	NLEP- Detection, referral, confirmation and registration of Leprosy case/after complete treatment for PB Leprosy cases/after complete treatment for MB Leprosy cases	100/200/400	0.14	8000(MB-4000 & PB-4000)	Part section.....	D	Just introduced in the state. An orientation plan is ongoing.	
6	VBDCP (Malaria)	5/- per slide	10	600000	Part	D	Just introduced in the state. At present it	



						section.....	is only for 11 districts, for rest of the 5 district planning is required.
7	To attend the delivery (if at home) in 18 HBNC blocks.	Rs.50 per delivery attended				Part A section.....	Yet to start
8	To make at least home visits for each neonate (during first month) in 18 HBNC blocks.	Rs. 150 per neonate provided the neonate survives for 30 days				Part A section .....	Yet to start
9	To accompany the sick neonate to a PHC/CHC, in 18 HBNC blocks.	Rs. 150 per case taken				Part A section .....	Yet to start
10	Blindness control	Rs. 175 per case				Part D section .....	
11	Navajat Swagath Bheit						
12	IDSP						



**The programme will largely involve these strategies:**

- Continuous training and support to the Mitans along with the social mobilization.
- Reduction of malnutrition with the application and practices of learnt skills by strengthening and deepening the health education and counselling work at the household level and by means of equipping the Mitans with BCC kit.
- Special focus for neonatal visits to reduce the neonatal mortality along with strengthening the Mitanin help desk and newborn corners in CHCs/24X7 PHCs.
- Facilitating Mitans instrumental for Inter-sectoral convergence among the related sectors at the habitation and Panchayats levels and strengthening local planning at Panchayats and village level.
- Strengthening the access of the poor to essential curative care through adequately provisioned women health volunteers. They are also linked to improved peripheral primary and secondary medical care facilities, through a functional referral system, Mitanin help desk (MHD). They enable the public health system to respond promptly and adequately to needs of institutional care of sick children, referred in by Mitans.
- To develop the logistic system for timely drug distribution under Mukhya Mantri Dawa Peti Yojana across district.
- Supporting and encouraging the Mitans to take local leadership through PRI.
- Facilitating the career path way for volunteer Mitans for B.Sc. nursing, GNM, ANM courses.
- To recognise the Social and system level problems faced by the Mitans. This is to motivate them and to advance the solidarity among the Mitans. District and block level "Mitanin Sammelans" or "Mitanin Diwas" of the women health volunteers to increase their motivation, ensuring their timely and correct incentive distribution, sustaining maintain their spirit of volunteerism and to strengthen their identity.

**Current year plan for the Mitans: The essential activities**

- Sustaining trained Mitanin supported by women health group in every hamlet. It will be helpful to maintain and stimulate the ongoing facilitation of service delivery by Mitans and community base of all health programmes is sustained through this. In a year, 8 days camp based and 24 days field based training would be organised for the women health volunteer. The key training will be on



1. *National programmes- HIV/AIDS and RNTCP (revision), NLEP (revision), Malaria (revision with new protocol on RDK, Artesunate) and National blindness Control Program (new).*
  2. *Revision of women health and women empowerment (leadership, atrocity, organising, Mitanins as convenor in VHSCs and facilitating the Village Health Plan etc).*
  3. *Revision of Mitanin dava Peti and strengthening of referral mechanism through Mitanin Help Desk with special focus on NCSP neonatal and childhood illnesses.*
- *Ensure that every sick child suffering from fever, diarrhoea, and ARI are visited on the very first day of illness with appropriate first contact care through use of Dawa Peti and referral where necessary. (For this smooth uninterrupted supply of drug to Mitanins will be ensured from state) also use of local herbals treatment for illnesses will be promoted by promoting Herbal Gardens at local level. Required support to AYUSH in development of Ayurgram in the district will be insured.*
  - *Provision of BCC kit to all Mitanins (in financial support of EUSPP) will be insured. Reduction of malnutrition will be addressed it at the hamlet level with the help of counselling skills by using BCC kit. Throughout the year a special emphasis on visit to family/ community groups will be celebrated as (Family visit Year) in which visit to neonates will be ensured on the first day after (even during) birth i.e., visit to the newborn on 3rd, 7th, 14<sup>th</sup>, 21<sup>st</sup> and 28th day/ once in second month in the neonatal period as per the Integrated Management of Neonatal Childhood Illness (IMNCI) and training. To ensure that appropriate classification, treatment and referral are done by the women health volunteer. Every six month infants (at least once in every 6<sup>th</sup>/7<sup>th</sup>/8<sup>th</sup>/9<sup>th</sup> months) will be visited and family will be counselled on complimentary feeding with the help of BCC kit. During visit to all pregnant (once every month) they will be counselled on general measures, access to antenatal care, and referred to an institutional delivery facility for childbirth. Mitanin will also facilitate support to new NRCs by referring severe and acute malnutrition (grade 3 &4) to NRCs in district across state. Thus through use of behaviour change kit in during above family visit impact upon malnutrition, IMR and institutional delivery will be made.*
  - *Ensuring the monitoring of all infant death in hamlets through Mitanins and its facilitation in VHSCs meeting and sending its information to all block officers.*
  - *Ensure strengthening of existing Mitanin Help Desk (MHD) at the district/CHCs level and its expansion to those PHCs which have huge OPD load for the strengthening of referral support system. Training of BMO's and DRP's on Mitanin Help Desk for the strengthening of referral support system. Effective functioning of the Mitanin help desk (MHD) in all the districts hospitals and CHCs along with its initiation in the*



identified PHCs shall ensure the participation of all Mitanins in Village Health and Nutrition day every month with greater involvement of VHSCs members.

- Shall ensure that Women Health Committees formed in the hamlets are regularly meeting and key health messages are discussed there. It also acts as a nodal point for health education and behaviour changes in certain areas. Active women health committee will support and result in forming active VHSCs which in further will be helpful in activating quality village health plan (VHP).
- Ensuring the strengthening of key operational activities of Mitanin Program viz. Hamlet level meeting, Cluster level meeting, VHSC meeting (Mitanin as convenor) MT meeting, DRP meeting. Shall ensure that Mitanins as a convener of VHSC will lead the process of village health plan at hamlet level with the support of MTs. No of Mitanins leading the active VHSC and developing VHP in guidance of Mitanin Trainers. They will also ensure timely and correct use of VHSC untied fund of VHSC.
- Ensuring implementation of Mukhya Mantri Swasth Panchayat Yojana through Mitanin cascade. Ensuring village health planning and its follow up.
- Mitanin will work as a convenor in the working committee of Ayurgram village in coordination with AYUSH and SHRC.
- Ensuring the timely reporting of Mitanin activity by use of newly introduced reporting format through Mitanins trainers, District Resource Persons and field coordinators (Mitanin Cascade).

### Indicators

1. Number of training attended by the Mitanin in days No of days training done for Mitanins.
2. Number of Mitanins using operational Mitanin/ ASHA kit.
3. Day 1 visits by the Mitanin during delivery and neonatal period to any home.
4. No of Mitanins using BCC kit during counselling of the families in hamlets.
5. No of Mitanins leading the active VHSC and developing VHP in guidance of Mitanin Trainers.
6. Number of qualified (10<sup>th</sup> and 12<sup>th</sup> pass) women health volunteers, Mitanin trainers and DRPs enrolled in vocational courses/ANM training to enhance their knowledge.
7. Number of women health volunteers getting incentive for social security.
8. Mitanin monitoring format is being finalised for the year 2010 – 11 and onward.

The impact of output indicators discussed above should be visible by a measured decline in child malnutrition rates, decreased low birth weight rates, decreased anaemia in women and decreased micro-epidemics and decreased epidemic deaths in gastroenteritis, childhood



acute respiratory infections and malaria and increased, community participation in village health plan as well as in panchayat plan. By all the above measures linked to improvements in the facility to reduce the infant mortality rate by the year 20011 -12 to below 35 {current the IMR of the state is 57 %( Rural 59%)}, (SRS-2008). Current malnutrition status of 52% shows that more than half of the children are the victims of one or the other form of deficiencies. So bringing down the malnutrition of the state to below 40% by the year 20010-2011 will also be the significant area of interventions (NFHS III-2006).

### **New thrusts**

1. Micro planning for delivery based on EDD is done with the assistance of women health volunteers at family level to promote institutional delivery in all possible cases or at least in those cases with risk factors
2. Mitanins are approached by a certain minimum number of families for common ailments and first level care is given and prompt referrals are initiated based on symptoms in all necessary cases.
3. Mitanins attending Immunization sessions at AWCs regularly as a token of solidarity and she is helping mobilization of the community for health services. (The important supporting factor here is the prompt disbursement of immunization camp incentives to Mitanins.)
4. Women Committees formed in the hamlets are regularly meeting and key health messages are discussed there.
5. Effective functioning of the Mitanin help desk (MHD) in all the districts hospitals and CHCs along with its initiation in the identified PHCs.
6. Increased community participation in village health plan at the village and Panchayat level. Better utilization of the services at the health centres as an impact of radio programs.
7. Spirit/mobility/self-esteem increased due to "Mitanin Sammelans" at the block, district and state level which will ultimately increase the quality of women health volunteer's output and thus will improve the overall impact of the program.

### **Institutional Mechanism:**

The programme will continue to be led by the state health society, coordinated on its behalf by the State Health Resource Centre and will be implemented at the district level by the District RCH (Health) societies.

SHRC will do TOTs of STT, DRPs, MTs and develop all training material for Mitanin programme, facilitates the Mitanin training at block level. SHRC will also monitor the entire Mitanin program and provide timely feedback.



**Budget Estimate Mitanin (ASHA) Programme**

S. No.	Unit	Unit cost	No. of Units	Duration	Cost (lakh)
<b>A.( I) Training and regular support for the strengthening of 60,000 Mitanins</b>					
1	Per day cost for Training of Mitanins	100	60000	6	360.00
2	Per day livelihood Compensation for Mitanins on training days	100	60000	6	360.00
3	Per day Training of Mitanin support team-Trainers (BRPs-1 per 20 Mitanins) Including RP cost	450	3000	10	135.00
4	Training of Block Coordinators (DRPs) including RP costs.	700	460	10	32.20
5	Per day Compensation for Mitanin support team-Trainers (BRPs)@2400 per month, { mobility, telephone etc. charges included}	120	3000	240	864.00
6	Per day Compensation for Mitanin support team-Trainers (DRPs)@4275 per month, { mobility, telephone etc. charges included}	175	300	300	157.50
7	Training Material (lump sum amount together for all material per Mitanin per year- at least three module and other )	150	66000	1	99.00
II	<b>Total(I)</b>				<b>2007.70</b>



<b>B. Mitanin Dawa Peti distribution</b>					
S. No.	Unit	Unit cost	No. of Units	Duration	Exp. per year
1	Mitanin Dawa Peti – Procurement ,logistics and distribution	6000	146	3	26.28
<b>II</b>	<b>Total</b>				<b>26.28</b>
<b>C Programme Management and Coordination</b>					
1	Block Level Programme Coordination and Monitoring ***	6000	146	12	105.12
2	District Level Programme Coordination and Monitoring *** cost per block	1000	146	12	17.52
3	State level Programme Coordination and Monitoring	6000	146	12	105.12
<b>III</b>	<b>Total</b>				<b>227.76</b>
<b>Total (A+B+C)</b>					<b>2261.74</b>
Allocation From ASHA budget under NRHM( For Mitanin Drugs one refill every two month of Rs 75 for each Mitanin- in addition to the allocation available with state budget- to fill gaps of chloroquine etc))					<b>270.00</b>
<b>Grant Total</b>					<b>2531.74</b>

### Mitanin Help Desk

#### Back ground-

The Mitanin program, launched in 2002, aimed that it will not only generate awareness but also assist the community in several possible ways to promote health seeking behaviour. Mitanin help desk is such one initiative.



### Concept-

The programme started at CHC and district hospital level, in Oct 2006 in districts Dantewada and Koriya. Then it ramified across state. A Mitadin Trainer/Mitadin provides her day services to CHC/ district hospital for

1. Guiding all the referral cases to obtain proper health services.
2. To facilitate the referred case to health staff.
3. Maintaining village / para wise record of referral cases.

This process helped immensely in addressing referral in timely manner.

### Process implementation

A detailed guideline has been issued to all district and blocks for creation of MHD.

Current status- blocks and districts where MHD is functioning.			
S. No. No	District	No. of Blocks	District Hospital
1	Koriya	In all 5 block.	yes
2	Korba	In all 5 block.	yes
3	Mahasamund	In all 5 block.	yes
4	Bilaspur	All 10 blocks	yes
5	Kanker	In all 7 block.	yes
6	Durg	In all 12 blocks.	yes
7	Rajnandgaon	In all 9 blocks.	yes
8	Kawardha	In all 4 blocks	yes
9	Dhamtari	In all 4 blocks	yes
10	Sarguja	In all 19 blocks	yes
11	Dantewada	In all 11 blocks	yes
12	Raigarh	In 9 blocks	Yes



### List of blocks and districts where MHD has to be launched

Sr. no	District	Blocks
1	Bastar	In 1 blocks-Orcha,
2	Janjgir-Champa	In 3 blocks-Nawagarh, Bamnidih, Malkharoda
3	Raipur	In 3Blocks- Aarang, Devbhog, Mainpur,
Number of referrals through Mitadin Help Desk across state – in Nov 2009 is 6783		

### Budget

S. No.	Mitadin Help Desk	No of unit	Unit cost	Budget (lakh)
1	District (Recurring cost Per month@4200 per district)	162	4200	6.80
2	Block-CHC (Recurring cost Per month@2400 per block)	1314	2400	31.54
3	<b>Total</b>			<b>38.34</b>

### B2 Jeevan Deep Samiti (RKS): Maintenance grant and Untied fund

Jeevan Deep Samiti plays a crucial in management of health facilities like district hospital, Community health centres and primary health centres .In our states RKS is kwn as Jeevan Deep Samiti.

To strengthen the JDS state has appointed 13 hospital administrators under the NRHM. Instructions are given from the state to all JDS to provide free services for institutional deliveries. The rationalization of specialist doctors, EmOC and LSAS trained medical officers are done to operationalise the FRUs.

### Objectives:-

1. Improved quality of health care in 17 district hospitals,145 CHCs,17 civil hospitals,716 PHCs
2. Ensure that all the district hospitals, CHCs, civil hospitals, and most of the PHCs are functioning as 24x7 hours health facilities.
3. Ensure that all facilities provide equitable access to women and adolescence.
4. Improve the Diagnostic facilities and Basic and Emergency Obstetric care through skill up gradation of existing staff and Outsourcing in some areas all centres



5. Organize the health camps in outreach areas and for special camps for Disabled children's.
6. Ensure the public participation and accountabilities through orientation of JDS members.
7. Identification of constrains and their solution like infrastructure gaps, deficiencies of specialist care, health referral system the etc.
8. Ensure skill up gradation of health staff through trainings and orientation workshops.
9. Ensure the establishment of Blood bank in all the district hospital and blood storage units in FRUs. Implementation
10. Ensure the Implementation of Citizen Charters in all health facilities.

#### Budget Requirements for Jeevan Deep Samiti

S.N.	Health Facilities	No of Units	Unit cost (Rs in Lakh)	Total Budget (Lakh)
1.	District Hospital	17	5	85
2.	CHCs	144	1	144
3.	Civil Hospital	17	5	85
4.	PHCs	715	1	715
Total				1029

#### Budget Requirements for Maintenance Grant:-

S.N.	Health Facilities	No of Units	Unit cost (Rs in Lakh)	Total Budget (Rs in Lakh)
1.	CHCs	134	1	134
2.	Civil Hospital	17	1	17
3.	PHCs	400	0.5	200
4.	Sub Health Centre	2500	0.1	250
Total				601

#### Strengthening of CHCs, Civil Hospital, PHCs, SHCs

Health Sector reforms under National Rural Health Mission aims to increase functional, administrative and financial resources and autonomy to field units so every unit needs



financial support. For undertaking innovative or responsive facility-specific local health action untied funds are required.

### Activities

1. Ensure the operational of health facility to provide quality health services.
2. Ad hoc payments for cleaning of health facility particularly after child birth.
3. Transport of emergencies to appropriate health facility.
4. Purchase of consumables according to need of health facility to deliver quality health care.
5. Filling of financial gap for delivering of health services or mobilization of health personnel and deceased during emergencies like disease outbreak, Natural calamities etc.

### Budget Requirements for Untied Funds:-

S.N.	Health Facilities	No of Units	Unit cost (Rs in Lakh)	Total Budget (Rs in Lakh)
1.	CHCs	144	0.5	72.00
2.	Civil Hospital	17	0.5	8.50
3.	PHCs	715	0.25	178.75
4.	Sub Health Centre	4776	0.1	477.60
5.	Civil Dispensary	29	0.25	7.25
Total				744.10

### B3 Untied fund for Strengthening the Village Health & Sanitation Committee

The Village Health & Sanitation Committee envisaged under NRHM is within the overall umbrella of PRI. The NRHM acknowledges that "Decentralization and Peoples' Participation" is essential for Health Sector Reforms and spells out details of institutional arrangements for Local Health Planning at Village level. It has been decided to formulate "Village Health Plan" to improve upon the health status of the villages. The initiatives at panchayat and hamlet level had been initiated much before through Swasth Panchayat Yojana and hamlet level meetings. Consolidation of hamlet level problems is in process through the formation of village health plans and establishing its linkage with Swasth Panchayat Yojana at the panchayat level. The implementation and monitoring work of will be carried out by SHRC in coordination with The Directorate Health Services and NRHM unit.



### **Current Status:**

*In current year, following activities are completed:-*

1. *In the state, the first activity carried out under this was the formulation of VHSC guideline in lieu of GOI guidelines. The following process were adopted for this*
  - *Consultation at various levels*
  - *Studied existing structures in other states.*
  - *A process for convergence of different committee of various departments at village level to ensure the focused and effective implementation of the schemes and programmers.*
  - *Incorporated suggestions of GOI guideline and suggestions given by National Health System Resource Centre (NHSRC).*
2. *Following features in VHSC formation in the state are ensured :-*
  - *Standing committee of Gram Panchayat leads VHSC. The president of VHSC is also a member of standing committee of PRI. All the ward panchs are member of VHSC.*
  - *Adequate representation of the weaker sections (Scheduled Castes, Scheduled Tribes, and Other Backward Classes) has been taken into consideration.*
  - *Mitanin (ASHA) is a convener of VHSC on yearly rotation basis. The approach to have Mitandin as the convenor is a step forward to fulfil the commitment towards women empowerment.*
  - *In addition to this, representation from non-governmental sector and Women's Self-help groups has also been ensured. The presidents of the village level all CBOs are the members of VHSCs. The composition of VHSC also includes at least 50% of women participation.*
  - *Special invitee members in VHSCs are - AWWs, Teachers, ANMs, hand pump mechanics.*
  - *Joint account in the name of Panchayat secretary and convener Mitandin.*

1. *More than 18500 VHSCs has been formed across state .The Untied Fund for the VHSCs of 20,308 villages has been released. It has been used more than 60% and collection of UCs is in process. In district Dantewada, Bastar due to the naxalite effected area*



S.N.	District/Blocks	Target	Formed	A/c. Opened	Money Transferred
1	Sarguja ( 19 Blocks)	1758	1758 (100%)	1743 (99%)	1677 (95%)
2	Janjgir Champa (8 Blocks)	898	898 (100%)	893 (99%)	853 (95%)
3	Korba (5 Block)	722	716 (99%)	716 (99%)	716 (99%)
4	Durg (12 Block)	1789	1774 (99%)	1771 (99%)	1769 (98%)
5	Koriya (5 Blocks)	655	644 (98%)	607 (92%)	606 (92%)
6	Bilaspur (10 Blocks)	1615	1568 (97%)	1438 (89%)	1429 (88%)
7	Jashpur ( 9 Blocks)	765	760 (99%)	749 (97%)	465 (60%)
8	Mahasamund (5 Block)	1173	1131 (96%)	1116 (95%)	1112 (94%)
9	Raigarh (9 Blocks)	1481	1429 (96%)	1429 (96%)	1424 (96%)
10	Kanker ( 7 Block)	1060	1000 (94%)	796 (75%)	714 (67%)
11	Rajnandgaon (9 Blocks)	1605	1597 (99%)	1580 (98%)	1474 (91%)
12	Kawardha (4 Blocks)	1009	943 (93%)	912 (90%)	868 (86%)
13	Raipur (15 blocks)	2180	1980 (90%)	1904 (87%)	1904 (87%)
14	Bastar (14 Block)	1563	1301 (83%)	1132 (72%)	790 (50%)
15	Dhamtari (4 Block)	657	529 (80%)	523 (79%)	499 (76%)
16	Dantewada (11Blocks)	1311	559 (42%)	424 (32%)	333 (25%)
<b>Total</b>		<b>20241</b>	<b>18587 (91%)</b>	<b>17733 (87%)</b>	<b>16633 (82%)</b>

2. Out of 716 VHSCs in district Korba, 1 (village-Chhuri, block-katghora) is now in newly declared urban area.
3. Rajnandgaon district has returned the Untied Fund of 103 villages because there are only 1605 Revenue villages.
4. A documentary film made over VHSCs role and responsibility, its use in training, block meetings, district meetings has helped in strengthening of VHSCs work. More than



10 VHSCs has been managed a building from Gram Panchayat. It's an effective initiative to develop VHSCs as an institution.

5. Strengthening of VHSC through Mitadin cascade; the Mitadin has been leading VHSCs as convenor. 18550 Mitadins as convenor led the strengthening process of VHSCs. They facilitated the government guideline. They have also facilitated the use of its untied fund in different social, Health, sanitation, institutional building and motivational activities. Following is the sample of more than 1000 VHSCs analysis, done on random basis. It clearly depicts that in leadership of Panchs as president and Mitadins as convenor, and with very small inputs to VHSCs in term of training, VHSCs are using untied fund in wide gamut of activities —

S. no	Different Head	List of activities
1	Health	purchase of children weighing machine, purchase of adult weighing machine, Kerosene spray, Pouring lime to ponds, Delivery table purchase, Epidemic information mobility, .banner for Malaria Yatra/Polio program, wall slogan writing, arrangement of milk for neonatal, . Purchase of child cradle, support for delivery, organizing health rally in village, Rally for Shish Sanrakshaan Month, Purchase of disposable syringe, Purchase of medicine for Mitadin Drug Kit medicines, Showing film
2	Sanitation	Hand pump cleaning, Drainage cleaning, drainage construction, tube well repair, Kerosene spray, Murram filling, Soak pit construction, well cleaning, water tank construction, platform for boring construction, Pond GHAT cleaning, Construction of boundary of well, Filling of pit, purchase of casing pipe for boring, allay cleaning Hand pump repairing, Construction of pipe in drainage system, Construction of SNANGRIH (bath room)
3	Social	bed net purchase, Information board( guideline), Treatment of poor, transportation for institutional delivery, Sitting platform construction, Tree cutting, help to Prerna Dal (local folk Media), Cutting of Gajar Grass, .treatment for malnourish children, Treatment of diarrhoea, financial support for crimination, Emergency support for patient, treatment of adolescent, God Bharai, Incentive to TBA for institutional delivery, Mitadin Name



		<p>Plate, Financial support in marriage of girl, Financial help to TB patient</p> <ul style="list-style-type: none"> <li>Saving untied fund-Contribution as SHRUMDAM</li> </ul>
4	Institutional development	<p>drum purchase, Chair purchase, Purchase of DARI, .purchase of different register/files/stationary for VHSCs, Opening bank account, .Information board for VHSC, Building for VHSC</p> <ul style="list-style-type: none"> <li>Without use untied fund-Initiating village health planning ( till now initiated in more than 1000 )</li> </ul>
5	Motivational	<p>Incentive to TBA for active work, Incentive to Mitandin for active work</p>

6. More than 65000 VHSCs members have been trained along with Mitandins on VHSCs guideline and village health planning. This has been resulted in initiation of more than 1000 village health plan across state. Some learning's from village health planning has been shown in following table-



### Some Learning from Village Health Plan, district Rajnandgaon

S. No	Name of the Block	Village	Identified Issues	Solutions Addressed through VHP
1	Dongergaon	Kulikasa	<ol style="list-style-type: none"> <li>Villagers taking bath in a small unclean pond and it was causing skin disease (itching )</li> <li>Village well was used for multipurpose task ( cleaning utensils , washing ,bathing ) and water logging around it</li> </ol>	<ul style="list-style-type: none"> <li>Discussed in the village level meeting and decided that Sachiv will be accountable to take forward the matter for a solution</li> <li>Sachiv wrote letter to PHED department</li> <li>They discussed this matter in village meeting with Sarpanch and punishment of Rs 51/- has been decided if any one use for cleaning utensils or clothes and bathing purpose . The announcement of it was made through Kotwar in the village</li> </ul>
2	Ghumka	Indamara	<ol style="list-style-type: none"> <li>The water supply tap is not working since one month</li> <li>Anganwadi worker is not available in the village</li> <li>Skin itching problems due to unclean water</li> </ol>	<ul style="list-style-type: none"> <li>Complement letter written to the Anganwadi worker and for repairing the tap.</li> </ul>
		Kaketara	<ol style="list-style-type: none"> <li>Water stagnation around the water tank of the village especially in rainy season</li> </ol>	<ul style="list-style-type: none"> <li>The responsibility to clean the area around the water tank was taken by the women of that hamlet</li> <li>The women cleaned the area around the water tank and also put a cover on the tank to keep the water clean</li> </ul>



		Magarlota	1. Mosquito net was not used by the villagers	<ul style="list-style-type: none"> <li>The issue was discussed in the village meeting and henceforth they started using mosquito net</li> </ul>
3	Chhuria	Chircharik	1. Disable girl of the village was not receiving disability pension	<ul style="list-style-type: none"> <li>The application was given at the Janpad level and the assurance was given by the officials that the girl will start getting the disability pension once the code of conduct will be over</li> </ul>
		Boirihdih	1. Water collection around the hand pump due to its multi usages i.e. for cleaning utensils, bathing , washing clothes etc	<ul style="list-style-type: none"> <li>Village level meeting was organized on the risk and impacts of water borne diseases.</li> <li>The SHG in the village volunteered to clean it</li> </ul>
		Pandey Tola	1. One old women was not receiving the old age pension by the panchayat	<ul style="list-style-type: none"> <li>She was facilitated to apply for it and there after she started getting the pension</li> </ul>
		Bholapur	1. ANM is not posted in village sub-centre	<ul style="list-style-type: none"> <li>ANM was posted at the sub-centre through continuous effort</li> </ul>
		Bhharitola	1. ANM resides 5 Km away from the village sub centre	<ul style="list-style-type: none"> <li>The issue was discussed with the BMO /ANM by the Sachiv of the panchayat .Series of written communication was undertaken with the BMO/ANM. This resulted in the ANM residing in the village</li> </ul>
4	Dongergarh	Bilhari	1. Problem in Institutional delivery and immunization because of non availability of building for the Sub-	<ul style="list-style-type: none"> <li>It has been decided the panchayat will write a letter for this</li> </ul>



			centre	
5	Chhukhadan	Rampur	2. The ANM resides in the village 1. Water was not coming in the tap due to less water force 2. The reason found was 10 HP pump is needed for this	<ul style="list-style-type: none"> <li>The matter was discussed with the panchayat and 10 HP pump was fixed</li> </ul>
		Korami	1. The beneficiaries have not received their wages under NREGA	<ul style="list-style-type: none"> <li>It has been assured by the Panchayat that within a month the account will be opened and the wages will be distributed to the beneficiaries</li> </ul>
		Jhuranadi	1. ANM is not posted in the village sub centre	<ul style="list-style-type: none"> <li>Application was given to the department and as a result of this they appointed one male candidate to fulfil the immediate need</li> </ul>
		Kumdhawada	1. Unclean village pond	<ul style="list-style-type: none"> <li>The issue was discussed in the village meeting and the responsibility to clean it was taken by the SHG</li> <li>Women SHG cleaned the pond</li> </ul>
6	Ambagarh chowki	Thailitola	1. Water connection was not given to 75 families	<ul style="list-style-type: none"> <li>The members of VHSC committee decided to give application to PHED for the extension of water supply line to these 75 households</li> </ul>
		Mahud	1. Powder milk was given to the malnourished child	<ul style="list-style-type: none"> <li>The counselling was given on the benefits of breast feeding and complimentary feeding to the family members of the malnourished child.</li> </ul>



					<ul style="list-style-type: none"> <li>The financial help of Rs 500/- was also given to the family</li> </ul>
		Telitola	2.	No supply of electricity in the village	<ul style="list-style-type: none"> <li>Letter was written by VHSC to the electricity department and request letter to the chief minister for the extension of electricity line from the main road to the village</li> </ul>
7	Khairagarh	Diwanbhedi	1.	The expansion of the water pipe line was pending since long	<ul style="list-style-type: none"> <li>The issue was discussed in the village meeting and the work started after 15 days of the discussion</li> </ul>
		Kiragi	1.	Waste collection around the hand pump because of children throwing their leftover of mid-day meal there	<ul style="list-style-type: none"> <li>The headmaster of the school was called in village meeting and the issue was discussed with him.</li> <li>After 5 days a dustbin was arranged to throw the leftover of mid day meal</li> </ul>



### **Operational objectives:**

- 1) To develop common understanding & generate awareness among the community, Community based Organizations (CBOs), members of Panchayati Raj Institution (PRIs) and representatives of government departments like teachers, hand pump mechanics, ANMs, AWW etc. This would help to disseminate the objectives and role of VHSCs, enabling to perform the expected actions of VHSCs as member and special invitee; effective utilisation of untied fund to address issues of equity and vulnerability.
- 2) To ensure the strengthening of the formed Village Health & Sanitation Committees (VHSCs) in the revenue villages, it will streamline the functioning of VHSC and thus to achieve its objectives. At least 50 VHSC will have their own building at the end of the year
- 3) To ensure the development of at least 6000 village health plan out of 19276 Village Health Plans in the villages this year, which will ultimately lead to conceptualization and framing of a Panchayat Plans.
- 4) Ensuring VHSC's role as community monitoring institution under NRHM.

### **Strategies: -**

1. Incorporation of NRHM Guidelines on regular basis. Providing each VHSC an untied grant of Rs.10, 000 for 2010-11
2. Capacity building of VHSCs members and various stakeholders. Develop VHSC member understands on Untied Grant component.
3. Conceptualization & formulation of Village Health Plans (VHPs) in accordance with the Health & Human development indices accumulated under Swasth Panchayat Yojana. Use hamlet level health data generated through the Swasth Panchayat Survey and the resultant Panchayat level Health and Human Development Index (HDI) as information tool for facilitating preparation of Village Health Plans.
4. An effective feedback and monitoring mechanism will be established to make planning process result oriented. Ensure regular facilitation of VHSC meetings through Mitanin Trainers and Resource Persons with help of State Health Resource Centre.
5. Integration of the VHSC with other programs like TSC etc
6. Institutionalisation of VHSC will be facilitated.
7. Use of Mitanin cascade for the implementation of all activities



### **Activities: -**

*The activities will be done through Mitadin Program cascade – MTs, DRPs and (FCs) Field Coordinators in close support and coordination with BMOs, CHMOs, and CEOs etc.*

1. *Regularizing monthly meeting of VHSCs and active participation of various stakeholders through joint and separate directive at regular intervals. Also establishing the block level Sachivs meeting, Sarpanch sangh meetings or facilitating platforms.*
2. *Ensure the active participation of VHSC in Village Health and Nutrition day to address coverage , malnutrition , immunisation , annaprashan, ANC services etc through capacity building , regular meetings and VHP*
3. *Ensuring the publication of the documented story of VHSCs in Mitadin Pati, Panchaman, departmental magazines and in other key newsletters.*
4. *Ensuring the monitoring and distribution of incentives to Mitadins under different programs, with introduction of Mitadin Pass book.*
5. *Two day training of five members from each VHSC will be done by MTs ( Mitadin Trainers ) and DRPs ( District Resource Person ) in presence of Medical Officer, PHC on micro planning, equity, vulnerability, VHP, institutionalisation of VHSCs and the scope of the utilization of the Untied fund Grant and the social audit aspect of it. With this the interventions like immunisation , institutional delivery, National Program RNTCP, Malaria, NLEP and also the updated directives from GOI etc will be given special focus*
6. *Structural monitoring and feedback measures will be taken for strengthening of Village Health & Sanitation Committees (VHSC) to ensure 100% registration of births and deaths in the villages and to address issues of Infant death & malnutrition, availability of safe drinking water and other key roles of it*
7. *Micro planning will be a major tool during the conceptualization & framing of the Village Health Plan (VHPs). To facilitate the process of micro planning linkages with PHRN, community monitoring framework , local NGOs and active involvement of different stakeholders will be addressed through gram sabha, cluster meetings, monthly meetings and meetings of women health committee etc . Ensure at least 5000 VHP against 19276 in a year documented plans will be used for advocacy and problem solving*
8. *Ensuring the role of Community Monitoring Framework (CMF) for effective functioning of VHSC at the state and the district level.*
9. *In institutionalisation of VHSC, its linkage with Gram Panchayat will be strengthened through activating the Standing Committee of it and in the block to state level*



actions. Efforts to be given to have joint or separate buildings VHSCs at least in 50 villages with the support of gram panchayats. For this, efforts should more be focused on strengthening of community process and its linkage with other local bodies or different departments.

10. Mitanin program cascade will be used for monitoring and feedback mechanism for the functioning of VHSCs and development of VHPs. In addition, CEOs meetings, Zila /Janpad meetings and other forums will be used for the development and rapid implementation of VHPs as well as for advocacy purpose.
11. To ensure active functioning of VHSCs in coordination with other departments like Women & child development department( WCD), Public Health & Engineering department( PHED), AYUSH, Education department, Bank, Health department, SIRD,SIHFW, SRC and Panchayat etc. It will promote and strengthen the inter-sectoral linkages among the sectors. Coordination with Public Health Resource Network (PHRN) will also be taken into account.
12. VHSC will work as working committee in developing 25 Ayurveda grams with the coordination of Ayush department while Mitanin will be convenor for it.
13. Ensure the participation of VHSC in four Gram Sabhas in a year to strengthen the community process. Ensure special gram sabha on VHP in every village. Addressing the dimensions of transparency and accountability through social analysis & audit in Gram Sabha.

#### **Main Indicators: -**

- 1) No of VHSCs functional i.e., regular monthly meeting
- 2) No of VHSC members received training on different interventions.
- 3) No of Gram Sabha conducting Social Audit of the utilisation VHSCs untied fund and no of special gram sabhas organised in village on health plans
- 4) Village Health Plans (VHPs) formed in all the revenue villages by considering village/hamlet specific issues.
- 5) Functional VHSC able to utilize the united fund grant properly that shall be visible by the No. of Social Audits in Gram Sabha, proper submission of Utilization certificates (UCs).
- 6) The number of VHSC carved out ways to channelize in-flow of funds and resources from various other developmental departments.
- 7) No of VHSCs participation in VHND every month.
- 8) No of JANSUNWAI (public hearings) done by VHSCs on SHC, PHC, CHC.



### **Institutional Mechanism:**

SHRC will facilitate the strengthening of VHSC through process like trainings, coordination among different stakeholders, development of training materials and documentation of VHPs etc. SHRC is also to monitor the VHSCs and to provide timely feedback to directorate.

### **Budget Requirement for Untied Fund for VHSC**

S. No.	Key heading	Unit Of Measure	Unit Cost	No. Of Units	Total Cost (Lakh)
1	Untied fund	No. Of VHSC	10000	19276	1927.60
<b>Total</b>					<b>1927.60</b>

- Training will be done under SPY (Swasth Panchayat Yojana) state fund.

### **B.3.1 VHSC Sammelans:**

Social Mobilization, inter sectoral convergence and coordination will be the key strategies for effective functioning of VHSCs. Convergence Sammelans at district level with involvement of various related departments, Block level Sammelans of VHSC leadership to develop vision and solidarity and encouragement using success stories of good work by VHSCs will be promoted.

### **Budget Requirement**

S. No.	Task	Unit Cost	No. Of Units	Total Cost (Lakh)
1	VHSC Sammelans at block level	10000	146	14.60
2	VHSC Sammelans at district level	5000	18	0.90
<b>Total</b>				<b>15.50</b>

### **B.4 Hospital Strengthening**

#### **DISTRICT HOSPITAL PLAN**

For the first time the district health plan has got separate chapter of district hospital plan the district hospital is the only secondary level hospital in the district, so to upgrade the curative and specialized care in the hospital following are the key priority areas identified.

1. To improve the quality of emergency service department in hospital.
2. To increase the inflow of patients to hospital-
  - :- Extension of hospital facilities in OPD and casualty
  - :- Conducting Satellite Clinics in remote areas



- :- Improving Facilities in Laboratory
- :- Improving the facilities of the hospital
- 3. To keep continues monitoring of malaria patients and measures to be taken to reduce the number
- 4. To maintain the efficient infection control measures
- 5. To increase the inflow of delivery cases and thereby promote the institutional delivery

#### Manpower Aspects

- 6. On account of maintaining the quality of services, adequate manpower is required so that better services can be provided to all patients.
- 7. To upgrade the quality of service rendered by the staff

#### Maintenance Aspects

- 8. To keep the system remain smooth and intact, hospital should keep all facilities functioning
- 9. To resolve the problem of imbalanced power supply

#### Management Aspects

- 10. The fund allocation of JEEVAN DEEP SAMITHI should be clear and crisp to everybody. Day to day expenditures are allocated from JDS.
- 11. To closely monitor the activities of all the employees in the hospital
- 12. To keep the medical services reliable, proper maintenance of medical records is needed.
- 13. Out sourcing of services

The essence of the district hospital plan is described as below.

#### Rajnandgaon

District Hospital Rajnandgaon is 100-bedded Hospital with a occupancy of 95% , it is territory level of Health care hospital located at Basantpur, Rajnandgaon it is the hospital equipped with Radiology, Pathology, OPD, IPD, O.T, Casualty, ICU, Administrative department , diet , laundry, Post-mortem, central store with highly skilled paramedical staffs , doctors and nurses.



### **Jashpur**

Dev Sharan District hospital was inaugurated in November 2008 as an updated civil hospital. It caters to approximately over 850608 populations coming from the local Jashpur district area and even the referrals from various CHC's, PHC's and their block. District hospital has specialist services like General Medicines, Orthopaedics, Paediatrics, surgery and dental care.

Hospital has 16 doctors, 14 Nurses and 100 bedded.

### **Bilaspur**

Sardar Patel district Hospital, Bilaspur started in 1956 has achieved its growth through the years with 2008 being an important year when it started working as an independent unit in its new building. With a capacity of hundred beds it has achieved more than 70% bed occupancy in just one year. Cater to the health needs of in and out of Bilaspur district; it has fully functional ten different facilities. And having radiological and pathological services at the hospital premises it is visited by around 8,000 patients per month and around 450 patients get admitted for various curative measures. Focusing on institutional deliveries it has achieved tremendous growth of 890 deliveries which is double fold as compared to last year's deliveries at hospital with no pending JSY payment.

Sardar Patel Hospital has approved bed strength of 100 beds, but the functional bed strength is 141. Hospital wants to expand to 200 beds. Which requires 19 more staff which will cost around 30,81,700 Rs Annually. Drugs and consumables cost of Rs 1,12,000 approx. Whereas outsourced services and AMC cost around 42,00,000 and 9,00,00,000 approximately. Training, accreditation, manpower development and equipment cost around 1.2 crores. The Total Budget required for PIP 2010-11 at Sardar Patel District Hospital is of Rs Five Crores Eighty Nine lakhs Twenty Three thousand Six hundred and Eighteen rupees only

The total running cost of the hospital is Rs 3,00,00,000 Approximately (includes manpower cost, out sourced services cost, AMC cost, drugs and Consumable cost etc). If funds are not available hospital just needs the running cost to be fulfilled giving the expansion plans a pause which as per the availability of funds to be considered quarterly or half yearly.

### **Koriya**

District Hospital Baikunthpur is one of the highly developed secondary care medical facilities in Chhattisgarh State with a capacity of 100 beds in In-Patient department which were inaugurated as District Hospital, Baikunthpur in 2000 by Honourable Chief Minister of MP



Mr. Digvijay Singh with covering 9 acres area .There is various number of Service providing by the hospital in 2009 as OPD - 85006, IPD-9530, Laboratory - 59193, Radiology- 4506.

But due to lack of infrastructure there is absent of facility in OPD area like ENT, Skin, Urology , Cardiology, Psychiatry, Radiotherapy, Neurology, Burn & Plastic, Dental, Physiotherapy Department and also there is lack of different IPD facility (Isolation Ward, Burn unit, ICU) inside the Hospital campus.

So hospital need the Budgets support from the Govt. Side for providing Quality service to the end user as Human Resource -1,24,96,800,infrastructure- 95,00,000 ,supporting material- 22,26,492 , Outsourcing for the supporting services -23,43,325, maintenance -23,43,325. There is also need the manpower & infrastructure support through the Jeevan Deep Samiti as costing of -20, 24,000 & untied fund for the different Miscellaneous Expenditure (Telephone ,internet Bill etc.) as 2,00,000.

The total running cost of the hospital is Rs 3, 12, 40,617 approximately (includes Infrastructure cot, manpower cost material cost, out sourced services cost, maintenance cost, and Miscellaneous cost etc). If funds are not available hospital just need the running cost to be fulfilled giving the expansion plans a pause which as per the availability of funds to be considered quarterly or half yearly.

### Janjgir Champa

District Hospital Janjgir is 100 bedded hospitals but on the operational side of it are only 30-35 beds. The hospital is full service oriented but due to lack of availability of Doctors and other paramedical staff the patient ratio getting down in the comparison of last year. For that increasing the patient ratio we would like to start the more inpatients wards for better healthcare delivery service. The different wards are to be introduced are ICU, SNCU, Maternal wards, Neonatal Wards etc. the total budget for this wards are Rs.1,316,0000.The manpower cost including Doctors and other Paramedical staff is Rs.54,66,000 and the maintenance cost for the ICU and SNCU including the equipment and wards maintenance is Rs.11,50000 annually. To introduce burn unit in district hospital it cost around Rs.1,33,0000.

The maintenance costs for equipment (USG and Telemedicine) are Rs.1, 30,000 and to start a first blood bank in a District and it would cost around Rs.20, 00,000. For the establishment of Dental Unit in a District Hospital it would be cost around Rs.5, 00,000. For the establishment of Bio Medical waste management system the amount required Rs.30, 000.

For the introduce of Non-medical service or support service like Dietary service, Laundry Service and Housekeeping and Administrative service the cost is around Rs.60,4000.



The total budget cost for the year 2010-2011 for district hospital Janjgir is Rs.2,43,70000 ( in words: Rs. Two Crore Forty Three Lacs Seventy Thousands)

### **Raigarh**

The Kirodimal Govt. Hospital (300 Bedded) is functioning in the Raigarh city since 1954.K.G.H.Raigarh is having good facilities of C.T. Scan, Sonography and Pathology tests. It's also having a medical store run by Red Cross Society which is providing medicines@ 5% below M.R.P. Blood Bank are also being run by the Red Cross Society. Dal-Bhat Kendra is also providing nutritious diet to patients at nominal rate.

The DH has its own building and the DH has a compound wall fencing all around. The DH has been functioning from the present building since 1998. Now the DH building is situated in the centre of the city and constructed in a small piece of land. Earlier it was sufficient as per city coverage but now as per the expansion of the city population it becomes the centre of the city and DH has no one more place for any more expansion.

The source of water supply for the DH is Bore well/Hand pump/ Tube well. Electricity is available in all parts in the facilities. The electricity supply to the DH is continuous and the generators are in working condition.

The District Hospital is connected to the municipal sewage for disposing off the waste but the waste is not segregated as infectious/ non-infectious. Patients are being made aware not to throw waste inside the hospital compound.

Currently there are only four staff quarters in the hospital compound which, though being utilized for residential purpose, are in shabby state. There are no staff quarters for CMHO, gynaecologists/ obstetricians, paediatricians and anaesthesiologists which is a very big demotivating factor.

There are 44%(approx) occupancy rate in the hospital, it must be enhanced in the coming financial year, that would achieved around more than 50%.There are no ICU, HDU(in working condition) in the hospital.

### **OPD and IPD Services:**

Both OPD and IPD services are available in the district hospital, OPD facilities are good in the district Hospital and OPD services for gynaecology/ obstetric and RTI/ STI are also available in the district hospital.



### **Korba**

Indira Gandhi district hospital, Korba is the first multi specialty health care delivery centre, achieved ISO 9001-2000 certification in public sector. It was constructed in 1987 and was inaugurated on 3<sup>rd</sup> March of the same year as an updated civil hospital. It caters to approximately more than 12 Lacs population coming from the local Korba district area and even the referrals from various CHC's PHC's and their blocks. The total area of the hospital is 6085.9 sq m in terms of built-up area and the whole premises has been extended over an area of 25 acres.

Offering services to 180 outdoor patients per day and an average bed occupancy rate of 99.99%, on 75 beds district hospital is having high progress in achievement. Now the hospital has commissioned to 120 beds.

### **Durg**

District Hospital Durg is 430 bedded Hospital. With the average per day OPD of around 850 patients and Average bed occupancy of 95% it boasts the pride to be the biggest hospital of the state. To describe some vital statistics in short is that DDH does around 1370 X-Rays per month & USG of 346 / Month and blood investigations of 11,000 per month. There are constant pressure from the public of the region to upgrade the general as well as technical facilities available at District Hospital Durg like Un-interrupted electrical supply, Continuous & safe water supply for drinking, Clean toilets, acceptable quality of food as per specification of diet recommended, free availability of medicine under IPHS norms for DHD, CT Scan, MRI, other higher investigation facilities, Renal Dialysis, Level 1 ICU management facilities, basic life saving & extended Medical services for Burn & Poisoning cases. Hospital, in its quest to render the best quality medical facilities have envisioned getting certified with ISO 9001 standards in the coming planning year. The PIP-2010-11 of District Hospital Durg comprises all such points that will facilitate to meet the abovementioned requirements.

### **Kanker**

District hospital Kanker a 100 bedded hospital on NH-43 has achieved new milestones since its existence in 2002 from a 7 bedded hospital to 100-150 and an extended provision of 200 bedded hospital with an average of 80% bed occupancy ,30% IMR & 50% JSY.

The new building at the hospital premises is functional with an extended facility of 200 beds and improved facilities with

- Burn ward, paediatric ward, isolation ward.



- The new hospital premises is WI-FI enabled campus with free internet accessibility on wireless LAN mode.
- ISO 9001:2008 ACCREDIATION HAS BEEN ACQUIRED
- Continuous improvement and record keeping with paperless file & record keeping.

Continuous and dedicated efforts to maintain the achieved accreditation standards and continuously improve it would require the following for the action plan of 2010-11.

### **Mahasamund**

The new building of District Hospital Mahasamund was started on 16th July 2005. It caters to approximately to a population of about 11 lakhs locally from the Mahasamund District & also referrals from various Community Health Centres (CHC), Primary Health Centres (PHC). Its distance from the main locality is approximately 3 kms, from bus station it is about 3.5 kms & from Railway station is about 5 kms. It is a 100 bedded hospital. The hospital building is covered by well defined boundary wall. Essential services (minimum assured services) including OPD, IPD and emergency services are available in the hospital. Apart from this, there are speciality services like General Medicine, Obstetrics & Gynaecology, Emergency, Ophthalmology & ENT are also available. There is no Intensive care unit (ICU) or High Dependency Unit (HDU) for treating critically ill patient. The average daily OPD is 170 approximately and are maintained in the OPD register. The bed occupancy rate is 38% (approx).

### **Dhamtari**

At Dhamtari civil hospital was started in 1976 with capacity of 50 bedded and posting of 5 medical officers. Civil hospital consisted of 5 OPD rooms one major O.T, 1 minor O.T, Office and Kitchen. Later on it was in years 2000 when Dhamtari was made district it was upgraded to 100 bedded hospital along with a 20 bedded Eye hospital. After the formation of district in the new set up govt have sanctioned 15 post of medical officers and 11 posts of specialists. It is also centre for IDSP, ICTC, RSBY which are running in old building. It is main referral centre from all peripheral rural health units. Taking all these into consideration the following PIP had been prepared for district hospital Dhamtari for the year 2010-2011.

### **SURGUJA**

The Raghunath District Hospital Was Started in Year 1933-34. In declared 300 bedded hospital by chief minister Dr. Raman Sing in 12 June 2004. It caters to approximately to a population of about 25 Lakhs locally From the Surguja district and also referrals From various Community Health Centres (CHC), Primary Health Centres (PHC). The total built up area of the Hospital is 32605 sqm. And the whole premises cover an area of 8.20 acres. Its



distance from the bus station is about 1 km. & 8 km. from the railway station. General information District Hospital has 31 Doctors and 33 nurses and 300 plus 40 bedded there are still need of various facility the district hospital like nephrologists storeroom conference hall residential quarter side lab minor O.T and O.T complex office set up generator maintenance central supply of oxygen and suction, CSSD, proper waste management R.O. system fire protection land escaping and salary of hospital consultant and data entry operator budget of 4,50,00000 /-

### **Kawardha**

District Hospital Kawardha was inaugurated on 12<sup>th</sup> of August 2005 by Honourable chief minister of Chhattisgarh Dr. Raman Singhji and is functional till date. District Hospital Kawardha is located on NH – 12A. .DH Kawardha a 100 bedded Hospital is located at distance of 1 km from bus stand. Hospital being a secondary care institution works as referral unit along with patient coming directly for medical services. Hospital provides Multi specialty services in area of General Medicine, General surgery, ENT, etc.

In year 2009 the total outpatients is 33803 & total inpatients is 3026. Total no of x rays done is 2673. Hospital has 12 Doctors and 15 staff nurses. Among Medical staff gynaecologist is needed on priority to start caesarean section so as to promote institutional delivery. Among technicians OT technicians, TMT technicians, Blood bank technician & one account assistant are needed.

Hospitals currently have no critical care medical services so as to need to start ICU as in Kawardha district no ICU is present including private hospitals.

Most of the wards & OT have floor which is needed to replace by tiles so as to facilitate cleaning & to reduce infections rate.

As power back up is concern only one inverter is available supplying OT & labour rooms .Another one would be needed to supply to other wards including administrative wing in case of power failure.

Process improvement of hospital services are needed facilitating through quality control which may require additional staff to coordinate quality improvements including training cost.

This is the first year where there is independent plan of district hospitals prepared by the civil surgeons and hospital consultants. As per their plan every district hospital has different needs requirement.



## **BUDGET.**

*To fund the gap in the district hospital operation state has plan to provide a flexi envelopes to the district hospitals. A total of Rs. 600 lacs. (@ 40 lacs per hospital to 15 hospital).*

### **B4.2 ISO Certification**

*Public hospitals are the only available social protection for the poor from disease, disability & death and from escalating healthcare costs. However, for too long poor quality of public health institutions and services provided through them have been matters of serious public concern. Shortage of facilities, increasing workload, ineffective systems and processes are making things difficult for providing quality service. Although the poor quality of services and infrastructure of public health systems has been attributed to poor motivation of the workforce, yet, there is growing recognition that the main causes of poor quality of public health systems are systemic – a reflection of both quality of hospital management and of public health administration. Patients often complain about the quality of services provided in the public health sector. Poor quality is causing loss of customers, loss of lives, loss of revenue, loss of material resources, loss of trust, wastage of time, and recognition.*

*Though the private healthcare providers profess themselves as champions of quality of care, they fail to address the equity concern, leaving majority of the population outside its network. Therefore, improving the service coverage and quality of care of public health systems has to be undertaken by the government, who is obliged to provide the healthcare services to the population.*

*First time in a county, Korba district hospital (**Indira Gandhi District Hospital**) has achieved first ISO Certificate in the country, followed District Hospital Kanker. This is a major achievement for the department of health & family welfare, Chhattisgarh. . The key technical players who helped the state to achieve this distinction are National Health Systems Resource Centre (NHSRC) and HOSMAC.*

*The success of this hospital has motivated the state to undertake such activities for every hospital in Chhattisgarh. During the year 2009-10, process has already started for district hospitals of Durg, Ambikapur and Bilaspur & four CHCs of Durg district for ISO certification for which in year 2010-11, amount for infrastructure development is required. The details are as follow*



**Table 3.4: Budget support for ISO certification process**

S. no.	Facilities	Activity	Units	Onetime cost	Handholding cost for 2010-11	Total cost for 2010-11 (lakh)
1	District Hospital	ISO certification	3	20,40,000	7500000	225
2	CHC	ISO certification	4	6,52,750	2500000	100
<b>Grand Total for 2010-11</b>						<b>325</b>

**B5 New Constructions/ Renovation and Setting up**

**B5.1 Closing Residential Gap**

To ensure availability of Doctors at the facilities it is required to provide proper residential quarters near the centres. Our state has envisaged operationalising all the CHC and 50% of the PHC to IPHS Standard. One of the major constrains to reach this standard is timely availability of doctors and paramedical staff. The proper residential staff will ensure staff availability of staffs. For this a PHC requires residential quarter standard by Chhattisgarh Government. The state is committed towards strengthening PHC and CHC through additional support to construct residential unit in the PHC and CHC. Residential unit is one of the most important need unless that it is very difficult to motivate the doctors and nurses to stay in the PHCs and CHC. Following are the need proposed for the year 2010 - 2011.

**Table 3.12: Budget summary for closing residential gap**

S. No.	Item	Measure of Unit	Unit cost	No of units	Duration	Total (lakh)
1	Closing residential gap	Multi-storey building at CHC	50 lakh	20	1	1000.00
2		PHC Residential building	25 lakh	60	1	1500.00
						<b>2500.00</b>

**B5.2 SHCs/Sub Centres**

Chhattisgarh has been putting a lot of effort and making steady progress in overall development of the state and especially in the health sector. However, due to various



constraints, development and progress could not be made as expected. With reference to this, the state still lacks in building and infrastructure especially those of health delivery centres. The new infrastructure situation is such that there is still a huge gap of CHCs, PHCs and Sub centres. Most of the existing centres operational are being used on rental basis. To build and develop this particular sector the state has sought support from various sources apart from the state's budget allocation for gap filling. Though the state is receiving support from the European Commission for the development of this sector there is still a dearth of funds for full fledge development for meeting the need of the beneficiaries as required and the state is also committed for this. With reference to this, the state requests fund support from NRHM flexi-pool. The requirement detail is as mentioned in the following table.

As per the decision taken by the state health society the infrastructural gap of PHC, CHC, District hospital will be taken by the state budget. sub health centre building construction will be taken by the NRHM budget. There are 4776 sub health centre has been sanctioned out that only 2346 has building .As per gap filling during the financial year 2010-2011 it is plan to construct 100 Sub health centre infrastructure building.

**Table 3.6: Budget support for Sub centres and PHC Infrastructure**

S.N.	Item	Unit Cost	No. of Units	Duration	Total (lakh)
1	Sub Centres	18.04	100	1	1804.00
<b>Total</b>					<b>1804.00</b>

## **B7 District Innovation**

NRHM is looking for a decentralized planning process beginning from the bottom- village, panchayat, block, district and up to the state. Districts prepare their district action plan according to the need of their districts following are some of the details of the details.

1. Durg-	ISO Certification 1 PHC and 1 CHC, out sourcing cleaning sanitation
2. Janjgir Champa-	Accreditation for caesarean delivery
3.Dantewada-	Out sourcing for IMNCI training, Mortuary van, Mortuary ( ICE freezer), Blood transport,
4. Bilaspur-	Active malaria surveillance, Family planning, emergency transport facilities. Neonatal stabilisation care unit, special camp for vulnerable group Baiga, Community support service, Special incentive for private



	Specialist,
5. Raipur-	Janani Suraksha disposable kit, emergency Solar system, Urban slum delivery point.
6. Rajnandgaon-	CUG mobile network for drivers. ANM and other staffs.
7. Korba-	Tribal Health Programme Pahadi Korba, Healthy Child Healthy India.
8. Mahasamund-	Leprosy active search, Leprosy self care and treatment and IEC/ BCC.
9. Dhamtari-	ANM training centre up gradation ,Primitive tribes ( KAMAR)
10. Bastar-	Construction of Shelter home at CHC, Urban RCH, Labour room
11. Raigarh-	Radio Programme , Cash support for confirm ANC, transport facility, nutritional support, Tribal Health programme for Hill Korba and Birhor, ISO certificate FRU Lailunga CHC Mega Camp with specialty clinic etc plastic surgery of congenital anomalies
12. Kanker	Micro birth plan, JSY counter, Urban RCH, weakly clinic at Haat bazaar
13. Jashpur	Pahadi Korba tribal health Check up , Immunization in , underserved area , Snake Bite, Blindness Mobility support to ANM in LWE and Remote areas

### Budget

As per the requirement of the district hospital plan a pool of Rs. 12 crore is budgeted for 18 districts, the amount will be released to the district as per the innovation need and prioritization.

#### B.8 Special initiative: Establishment of Snakebite Case Management Unit in district hospital

Snakebites are quite high in northern and southern Chhattisgarh. Every year, despite all the preparatory measures as well as remedial interventions, many people die. To address this, we plan to ensure timely and proper first aid to the affected, where we shall train a set of motivated volunteers who shall initiate suitable first contact care for the patient. In the last financial year, a pilot project was already implemented in the Jashpur District we got great success to save life's. In current year, effort is taking to scale up this program in entire 18 districts. So here additional budget requirement for further equipping the district is Rs. 1800000 is put forward. The requirement involves the refilling of the anti venom vaccine as



well as anti venom powder and that of ventilators. Similarly quick transport and referral of the patients will ensure. The ambulance and ventilator will be utilised with the available vehicles in the districts. The additional budget required will be for Anti venom, incentives for Referral and training and IEC for snake bite etc.

#### **Budget Summary for Snakebite case management**

Sl. no	Description	Unit Cost	No. of Unit	Duration	Total Cost
1	<b>Snakebite case management</b>	100000	18	1	1800000
<b>Total</b>					<b>1800000</b>

#### **B.8.1 Chhattisgarh Rural Medical Corps**

- 1) **Objective:** To provide improved & efficient health services in the difficult and remote rural areas of the State by engaging the services of working and retired persons of Department of Health and Family Welfare as well as minimally qualified persons of the private sector for the appointment of specialist doctors, medical officers and staff nurse in the medical institute situated in these areas.
- 2) **Scope of the Scheme:** the posts of Chhattisgarh Rural Medical Corps Scheme will include all the posts sanctioned by the State Government and the posts sanctioned by the National Rural Health Mission in the difficult and most difficult health institutes defined according to Appendix – 1 (Community Health Centre and Primary Health Centre) and Appendix – 2 (District Hospitals) . The state can amend the list of number of institutions district wise from time to time as per our requirements.
- 3) **Chhattisgarh Rural Medical Care Incentive Package:**

**3.1 Monthly Incentive Honorarium:** Every incumbent employed under Chhattisgarh Rural Medical Care Institutions will be given monthly honorarium as detailed below:

- (a) Apart from pay and allowances prescribed by the Government, the staff working in Chhattisgarh Rural Medical Care Institutions will be given a fixed monthly incentive amount on appointment in the difficult and most difficult areas, as the case may be, by the National Rural Health Mission as per the enclosed appendix.
- (b) Due increase will be made in the monthly incentive amount after every 2 years as mentioned in Appendix -3.



**3.2 3.2 Group Insurance Scheme:** The Group Insurance of officers/ employees mentioned in the scheme will be done during the period of employment to cover death or permanent disability resulting from accidents.

**3.3 3.3 Compensation in the event of naxalite violence:** If an officer/ employee dies from the naxalite activities in course of discharging the duty, his dependents will be given a sum of Rs. 10 Lakhs under this scheme. If anyone gets injured from the naxalite activities, the entire expenses of his treatment shall be borne by Chhattisgarh Rural Medical Corp.

**3.4 3.4 Relaxation in qualification period for admission in PG Course:** The Medical Officers serving in Chhattisgarh Rural Medical Corps will be deemed eligible for admission in PG Courses for the seats reserved by the State Government for government assistant surgeons. This eligibility will come into force after providing 3 years of service and for this purpose due amendment will also be made in the existing rules of admission to PG courses. Such selected medical officers of CRMC Scheme will have to compulsorily tender service of at least 2 years in Chhattisgarh Rural Medical Care after completion of their PG Courses. The medical officers will not have to request for study leave separately for post graduation education but the amount of special incentive of Chhattisgarh Rural Medical Corps will not be paid for the period of post graduation courses.

**3.5 3.5 Government Accommodation:** If the officers/ employees working under Chhattisgarh Rural Medical Corp have been allotted government accommodation in the previous appointment place, they will have the option of keeping up the occupation of the government accommodation for the agreement period.

**3.6 3.6 Residential Option:** The medical officers incumbent in the Primary Health Centres of the most difficult category will have the option to give their choice as to the residence in the Head Quarter of the concerned development block but under this circumstance, only a fixed incentive amount will be payable to him for the Community Health Centre.

**3.7 3.7 Leave Travel Concession:** In conformity with the LTC to be given to the Central Government employees, the officers/ employees working under CRMC Scheme too will be given the benefit of LTC facility.

#### 4) Period of work:

**6.1 Period of Agreement:** The period of work under CRMC scheme will be 4 years (period of agreement). Generally an attempt will be made that the officers/ employees may be posted for 2 years in the most difficult areas and two years in the difficult areas.



**6.2 Increase in agreement period:** If after the completion of four years service under the CRMC Scheme, any employee gives the option of being re-included in the scheme, he may be reengaged in the scheme for another two years.

**6.3 New appointment after the completion of the service period of Agreement:** 3 months before the completion of the period of service under the scheme, orders will be issued regarding appointment in general category institutions not included in CRMC scheme and the staff concerned will be informed of their place of new appointment. The orders of restriction of general transfer of the government will not apply to the above mentioned transfer made under CRMC scheme.

**6.4 Termination of agreement before the agreed period of service:** If any employee working under the CRMC Scheme gives an application to leave the scheme without completing four years of service, the authority to make a decision on it will be vested with the Commissioner Health Services. For this, it will be mandatory for the concerned employee to intimate 3 months in advance and has to deposit a sum equal to the incentive amount of 1 month to the account of State Health Society. In case of approval of termination of MOU, the concerned employee will be deemed as an employee of general category despite being incumbent in the CRMC Scheme Institutions.

**For Transfer:** The transfer rules of the government will apply to such employee.

**6.5 Transfer by mutual consent:** The staff working under CRMC Scheme and the staff working in general category institutions may be transferred by swapping their places of posting on the basis of mutual consent. For this purpose, the desirous officers/ employees will have to make applications jointly to the Commissioner, Health Services. The Commissioner, Health Services is the authority competent to decide on the application but under the circumstances, the staff belonging to general category institutes under CRMC Scheme will have to enter into an agreement of four years' period.

## **5) Process of implementation under the scheme:**

**5.1** First of all, choices will be invited from Govt. and contractual staff already posted in Institution coming under CRMC Scheme institutions to work under CRMC Scheme.

**5.2** Subsequently, choices will be invited from the staff incumbent in the institutions of general category for the remaining vacant posts in CRMC Scheme institutions.

**5.3** In case of non-fulfilment of posts from Government staff working in the Department, the retired officers/ employees of the Department and the persons



possessing the minimum qualifications as per rules of the Government may be appointed on contractual basis for the vacant concerned posts.

**5.4 Agreements after Retirement:** If the employee working under CRMC Scheme institutions gives his choice 3 months prior to retirement, to continue working even after retirement, he will be deemed self appointed in the contractual service under the CRMC Scheme .The maximum period of such contractual service will be limited up to the period of four years by the concerned employee in the CRMC Scheme or his completion of 65 years of age, whichever is earlier. The amount of incentive in this type of contractual service will be prescribed by the Government separately.

**5.5** The appointment of the officers/ employees working under CRMC Scheme to CRMC institutions of general category may be made by the Commissioner as per the recommendations from the Mission Director, NRHM.

#### 6) Financial Provision:

**6.1** This scheme will operate under National Rural Health Mission and on the expiration of the Mission, the scheme will be deemed expired itself. Necessary financial arrangement for this scheme will be made under National Rural Health Mission.

**7) Evaluation of work:** Minimum norms of the performance for the continuous improvement in the achievement of the functions of the Institutions under the scheme have been laid down for the District Hospitals, Community Health Centres and Primary Health Centres falling under Chhattisgarh Rural Medical Care as mentioned in the enclosed Appendix (5.1 to 5.4).

The officers and employees of the Institutions obtaining the minimum achievement in conformity with the said norms will be given the amount (Appendix 3) provided for under the scheme but for the officers and employees of the Institutions not obtaining the minimum achievement in conformity with the said norms, the increment in incentive to be given in the 3<sup>rd</sup> and 4<sup>th</sup> years as provided for under the scheme will not be done. Besides, in case of non accomplishment of the minimum laid down norms of performance, the contract of all the employees of the Institutions concerned may be terminated after 2 years.

The present staff position sanctioned & vacancy is indicated in the following table.

Sl. No.	Name of Post	Sanctioned Post	In position	Already Agreement
1	Specialist + PGMO	578	86	71
2	MBBS	1264	657	445



3	<b>Staff Nurse + Nursing Sister</b>	1008	409	326
4	<b>RMA</b>	472	465	437
<b>Total</b>		3322	1617	1279

**Budget:** - It is expected that approximately half of the sanctioned staff positions will be filled this year i.e. 1300 posts approximately. Hence an amount of Rs. 82700000 (Eight crore Twenty Seven lakhs) will be required as honorarium under CRMC scheme this year. This is calculated at 35 % of the total amount of Rs. 23.38 crores required for payment of honorarium to all staff employed under CRMC Scheme.

Category	Number of institution		Honorarium Amount per institution		Sub Total		Total (lakh)	35% of total amount (lakh)
	Hard	Hardest	Hard	Hardest	Col. 2*Col. 4	Col.3 * Col.5		
300 bedded District Hospital	1	0	39.84	0	39.84	0	39.84	13.944
100 bedded District Hospital	2	5	30.3	41.52	60.6	207.6	268.2	93.87
Community Health Centre	31	45	9.36	12.24	290.16	550.8	840.96	294.336
Primary Health Centre	0	472	0	2.52	0	1189.44	1189.44	416.304
<b>Grand total</b>							<b>2338.44</b>	<b>827.454</b>
Rs. Eight Crores Twenty Seven Lakhs Only								
Calculations made as per the incentives given to each staff on appendix -3 & no. of sanctioned positions in each institution								



## B.8.2 Strengthening the role of Panchayati Raj Institutions in Health

**Situational Analysis:** Panchayati Raj institutions have been encouraged to participate in community health programmes of the state, starting from the selection of Mitanins with ratification by Gram Sabhas itself in 2003. The 4<sup>th</sup> Round of Mitanin Training on Malaria included one day of Panchayat based planning on Preventing Malaria.

The 7<sup>th</sup> Round of Mitanin Training was specifically on sensitizing the Sarpanchs on issues of health. This was done by introducing the concept of 'Swasth Panchayat' i.e. a healthy panchayat. The training focused on a dialogue with Sarpanchs on what constitutes a 'healthy panchayat'. A Panchayat Health Diary was introduced through Mitanin Programme and the State Health Resource Centre in year 2006. The Diary was given to each Sarpanch and it points out the specific actions that a Sarpanch can do in order to make his/her Panchayat 'healthy'. Sarpanch Health Sammelans were organized in most of the districts in the state in 2006 with active support from District Collectors and Zila Panchayats. These Sammelans were attended by thousands of Sarpanchs and helped in sensitizing them on issues of health.

The first Swasth Panchayat survey was carried out in 2006 with active participation of Panchs and Sarpanchs along with Mitanins. It collected data on 26 health and related indicators at Panchayat level. Based on the indicators, panchayat HDI scores were computed. The two top ranking panchayats in each block were given cash awards. The bottom ranking two panchayats were given cash support so that they can work towards improving their performance in the coming year. The second Swasth Panchayat Survey was carried out in 2007-08 based on 32 indicators. The key issues brought out in these grassroots plans were fed into the State PIP for NRHM.

The concept of Village Health & sanitation Committees (VHSC) was introduced by the National Rural Health Mission in 2007-08. In Chhattisgarh, VHSC is a sub-committee of the Standing Committee of the Panchayat on Health, Education & Social Welfare. The Panch heading the Panchayat's Standing committee also chairs the VHSC. The Panchayat Secretary is also the VHSC's secretary and one of the bank signatories along with the Mitanin who plays the Convener's role. Most of the Panchs are members of the VHSC. Thus VHSC initiative in Chhattisgarh is based on close collaboration between PRIs, Mitanins and local service providers like ANMs and Anganwadi workers. Mitanin Programme has been playing the facilitating role in formation, activation and capacity building of VHSCs.

Gram Swasth Niyojan Abhiyan, a social mobilization campaign around VHSCs and Village Health Planning was launched in 2008-09. As part of this campaign, more than 10,000 Panchayat/village based events were organized. One key component of this campaign was



to introduce and initiate Village Health Planning by organizing special Gram Sabhas across the state. The 11<sup>th</sup> Round of Mitadin Training on Village Health Planning in 2008-09 has also been done jointly with Mitadins, Sarpanchs and Panchayat Sachivs.

The third Swasth Panchayat Survey was concluded in November 2009. Its analysis is being fed into developing decentralized health plans at VHSC level and then attempt is being made to incorporate these into block, district and state level PIPs of NRHM. Currently, Village Health Planning is one of the key activities being promoted through Mitadin Programme in collaboration with PRIs. Under this initiative, more than 3000 villages have prepared Local Health Plans with active involvement of VHSCs and Gram Panchayats.

**Objectives:** Enhance PRI participation in health in the following ways:

1. Enable PRI participation in well informed and evidence based village health plans
2. Allowing PRIs to know their performance and encouraging them to improve it
3. Incorporation of village health plans and situational data into block and district health action plans

**Strategies:**

1. Community Mobilisation around PRI participation in health
2. Active facilitation of Village Health Plans with PRI involvement
3. Active dissemination of Panchayat level health indicators and HDI based ranks
4. Distribution of Prizes to 2 best performing Panchayats (Rs.10,000 and Rs.5000 respectively) and cash support to 2 weakest panchayats (Rs.5,000 each) in every block

**Activities**

- a) Training for Swasth Panchayat Survey
- b) Data Collection for Swasth Panchayat Survey
- c) Data entry and analysis
- d) Distribution of Swasth Panchayat prizes and cash support
- e) Dissemination of Swasth Panchayat Survey

Strengthening PRI Role in Health: Budget for 2010-11			
Item	No.	Rate	Amount (lakh)
<b>To be sent to District Health Society</b>			
Cash Prizes and Support for ranked Panchayats	146	25000	36.50
<b>To be budgeted by SHRC</b>			



Training for Swasth Panchayat Survey	3000	75	2.25
Data Collection and Community Mobilization	9400	500	47.00
Data Entry and Analysis	9400	20	1.88
Dissemination	9400	100	9.40
<b>Total</b>			<b>97.03</b>
The amount to be provided from the State budget. (cash prizes for panchayats )			36.50
Amount required from NRHM			<b>60.53</b>

### B.8.3 Mainstreaming of AYUSH

S. No	AYUSH activities under NRHM	Time Frame	Expected Outcome	Budget Allocation (in Lakh)
1	AYUSH Health Melas at District and Block Level	Q1-Q4	Increasing the service outreach and increasing the popularity of the system.	97.20
2	Flexible untied fund for AYUSH Deep Samiti as mobility support	Q1-Q4	Improving monitoring strategy	17.16
3	Contractual Appointment of AYUSH Medical Officers in the underserved areas in phase manner	Q1-Q4	Increasing the AYUSH Coverage in the state	90.00
4	Infrastructural Development of Labour Ward Facilities at the selected dispensaries	Q1-Q4	Improving the Maternal Health care Services in the AYUSH Setup	35.00
5	Yoga Popularization in Ayurved Gram	Q1	Yoga Training for Mitanin	1.08
		Q1- Q4	Incentive to Mitanin for yoga	17.52
6	AYUSH Deep Samiti	Q1-Q4	Improving the facilities at dispensary/Hospital level	176.00
7	AYUSH Programme Assistant	Q1-Q4	Monitoring the AYUSH Schemes under NRHM and the data collection and validation in the large districts.	21.60
8	Exchange programme by External Experts and Consultants for Ayurveda	Q2-Q4	Increasing the core competence of Ayurveda Medical Officer.	4.80



	<i>medical Officers</i>			
9	<i>Prevention of disability in leprosy cured persons through Homeopathic Medicine</i>	Q1-Q4	<i>Reduction in the prevalence rate of leprosy in the state.</i>	44.82
10	<i>National Consultative Workshop for creation of roadmap for mainstreaming</i>	Q2-Q3	<i>Developing the strategy for mainstreaming</i>	0
11	<i>AYUSH Technical Assistance</i>	Q1-Q4	<i>Enhancing the Quality of AYUSH service by good planning and monitoring</i>	0
12	<i>AYUSH Training for Anganwadi Workers</i>	Q1-Q4	<i>Improving maternal and child health by AYUSH principles</i>	0
13	<i>Additional Manpower for tribal CHC/PHC</i>	Q1-Q4	<i>Increasing the AYUSH Coverage in the state</i>	0
			<b>TOTAL</b>	<b>505.18</b>

**Note:** The highlighted budget head is carry forward from 2009-10 to 2010-11

#### **AYUSH Health Melas at District and Block Level**

Popularization of Ayurveda based curative care and promotion of Indian systems and Homeopathy needs to be further emphasized as the deserving level of outreach still lacking in want of proper facilities, infrastructure and manpower. In order to bridge this alternative strategy needs to be worked out like putting consolidated efforts pooling the available manpower to centralize location where people could be mobilize and all available services could be provided along with effective IEC on a planned manner. The state is proposing to organize AYUSH Mela four times in a year at block level and a mega bi-annual Mela at the district level. The district areas and the block level villages are selected by patient outreach and deficiency in service outreach by the District Ayurveda Officer. The service outreach in the left out and difficult pockets can be served by the other mode of strategy as AYUSH Melas which shall increase the popularity of the system greatly. The budget for this shall be 15000 Rs. Per Block Mela and 30,000 Rs. Per District Mela.

S.NO	Unit Description	Unit Cost	No of units	Duration	Total Cost (lakh)
1	Block level Melas	15,000	146	4	87.60
2	District Level Melas	30,000	16	2	9.60
	<b>Total Cost</b>				<b>97.20</b>



## **FLEXIBLE UNTIED FUND FOR AYUSH DEEP SAMITI FOR MONITORING**

District Ayurveda officers are functional in all the 16 districts of the state. They shoulders the major responsibility of administration, execution of Central and state level plans at the district level, monitoring the AYUSH health care institutions efficient functioning in the district ,management of AYUSH human resource and supply of essential AYUSH medicines to the District Ayurveda Hospitals and AYUSH dispensaries in the district.

Monitoring of District Ayurveda hospital, AYUSH dispensaries and AYUSH wings in allopathic centers for effective functionality is ensured by District Ayurveda officers. Monthly review meeting of the AYUSH physicians and understanding the difficulties faced by the Physicians as infrastructural gaps, manpower gaps and facility gaps are assessed by the District Ayurveda officers and solutions provided by District Ayurveda officers.

Monitoring of AYUSH institutions in difficult areas and far off places by District Ayurveda Officer needs to be supported by conveyance facility as hiring of the vehicle for mobility within the district. This facility can enhance monitoring process and supervising activities under their jurisdiction, the other utility of mobility support are monitoring the camps conducted at district and block level .Minimum two visits to every District Ayurveda Hospital, AYUSH dispensary and AYUSH units in a year is Essential. This fund will be transferred to District AYUSH DEEP SAMITI where the District Ayurveda Officer can draw the money from AYUSH Deep Samiti. The District AYUSH DEEP SAMITI will be nominated for monitoring of utilization of untied funds. The district Ayurveda Officer can hire a vehicle, from the flexible untied fund for effective monitoring of the districts. The fund allocated has been calculated with the number of dispensaries in the district, the total number of visits planned in a year by the district Ayurveda Officer.

S.NO	Unit Description	Unit Cost	No of units	Duration	Total Cost (lakh)
1	Mobility support for District Ayurveda officers	Varies with every districts plan For monitoring and mobility	16	1	17.16

## **Contractual Appointment of AYUSH Doctors in underserved Nontribal PHC**

As per the IPHS norms the one or AYUSH physicians to be placed in the Allopathic Health Care Units. The placement of AYUSH manpower in PHC where the other forms of AYUSH services are not available. The PHC where AYUSH man power is to be placed is selected from the PHC situated in remote areas of non tribal areas. The list of PHC which are present in the difficult areas are identified by the state in CRMC data and such 50 centres will be identified from the list on pilot basis.



S.NO	Unit Description	Unit Cost	No of units	Duration	Total Cost (lakh)
1	Contractual Appointment of AYUSH Medical Officers in PHC	15,000	50	12(months)	90.00

### **Infrastructural Development of Labor Ward Facilities at the selected dispensaries**

The institutional deliveries in the state as per SRS data 2007 which indicates the data to be very poor as 18%. To improve the institutional deliveries increasing the institutions providing labor services is essential. AYUSH dispensaries can be developed into institutions providing labour and delivery services. The AYUSH inputs in improving the institutional deliveries is not remarkable and to enhance this the development of infrastructural facilities in selected institutions in rural areas is essential. The AYUSH Medical Officers who are to be trained in Essential Maternal and Child Health Training shall conduct the deliveries and improve the coverage in Reproductive Health Care. Hundred AYUSH dispensaries are selected in the state where the possibility for development infrastructure and equipping the centre with all facilities for the conduction of normal deliveries. Installation of the labour table and delivery kit in the AYUSH dispensaries where space provision is present for conduction of normal deliveries in the AYUSH dispensaries is expected. AYUSH doctors with the help of locally trained paramedics/Dias/Mitanin will conduction institutional deliveries. The fund allocated at state level shall be transferred to AYUSH Deep Samiti's of the districts for the development of facilities at dispensary level for conduction of labor. Provision of incentive to the AYUSH doctors and the manpower assisting in conduction of deliveries shall be included in NRHM after the development of infrastructural facility.

S.NO	Unit Description	Unit Cost	No of units	Duration	Total Cost (lakh)
1	Infrastructural Development of Labour Ward Facilities at the selected dispensaries	35,000	100	1	35.00

### **Yoga Popularization in Ayurvedgram**

Health in the hands of people was the aim for the development of Ayurvedgram Scheme. To attain health through the promotive principles of Ayurveda and Yoga was the major activity in the scheme. One Mitadin or any volunteer of the Village associated with Health related activities in 121 villages are to be selected for training in Positive Health through Yoga. The training is to be conducted for all the villages under the scheme in coordination with the Morarji Desai National Institute of Yoga or any other reputed institutions. After the training the activities like training of school children in yoga, village level yoga club development.



Propagation and promotion of yogic life style in the selected villages. To motivate the person propagating the yoga practices in positive health is essential for improving the popularity of yoga in the villages.

The training is to be conducted by MDNIY or any other reputed institutions and the total cost for the training programme is 90,000 and MDNIY or any other reputed institute shall bare 70% of the cost and rest 30% needs to be added in the PIP.

S.NO	Unit Description	Unit Cost	No of units	Duration (Months)	Total Cost (lakh)
1	Yoga Training for Mitanin	27000	4	1	1.08
2	Incentive to Mitanin for Yoga popularization	1000	146	12	17.52
<b>Total Cost</b>					<b>18.60</b>

### AYUSH Deep Samiti

The state is having seven district Ayurvedic hospitals and 692 AYUSH dispensaries. Also as part of mainstreaming AYUSH, mainstreaming facilities are getting ready to provide various AYUSH services. In this context, it is very important that the AYUSH department should be equipped to look after and manage various AYUSH facilities in a systematic manner. As identified by the State this could be addressed by setting up facility management committee in the same line of Jeevandeep Schemes that is already operational in the states for ensuring reforms based hospital management in all the AYUSH facility. The AYUSH Deep Samiti formed are 648 where the Samiti is functional, only for these Samiti the fund allocation is essential. Accordingly, a programme in the name of Ayushdeep scheme is being drafted where setting up quality criteria for AYUSH facilities, training of functionaries on facility development as well as management, untied fund for up gradation of facilities are built in. The untied grants for the facilities as budget shall be provided for the enhancement of the facility at the dispensary level.

S.NO	Unit Description	Unit Cost	No of units	Duration	Total Cost (lakh)
1	Flexible untied fund for facility enhancement in AYUSH units	25000	648	1	162.00
2	Flexible Untied fund for development of infrastructural facilities in the district Hospitals	2,00,000	7	1	14.00
	<b>Total</b>				<b>176.00</b>

**AYUSH Programme Assistant**



Fund allocation under NRHM Schemes of AYUSH for AYUSH in the Health Melas and AYUSH Deep Samiti needs surveillance, monitoring and timely data collection for effective implementation. In the state has to be monitored in the State. The districts where large number of AYUSH dispensaries are present, it is difficult to collect the data and compile the data. Regular monitoring of the activities in the NRHM Scheme and the timely data collection in AYUSH. AYUSH programme assistant needs to be placed by which there is effective data collection and validation. The programme assistants will be under the control of DPM and daily reporting of AYUSH activities under NRHM and other data's reported to the DPM. The salary will be routed thorough district Health society and the roles and responsibilities shall be defined jointly by Department of AYUSH and DPM. The recruitment shall be undertaken by NRHM.

S.NO	Unit Description	Unit Cost	No of units	Duration	Total Cost (lakh)
1	AYUSH programme assistant	10,000	18	12	21.60

#### Exchange programme for Ayurveda Medical Officers by External Experts and Consultants

The Total AYUSH dispensaries functioning in the state are 692. The total AYUSH Man power functional in the state in the AYUSH setup or Allopathic health network are 1152. The AYUSH Man power are to be competent and the capacities need to be upgraded in their own discipline where the new research work are incorporated and in other disciplines like basic emergency management, RCH and research methodologies. The lecture to be undertaken for the Ayurveda Medical Officers is assessed by the District Ayurveda Medical Officer by the assessment of the Health Status of the district and the total two in every district.

S.No	Unit Description	Unit Cost	No of units	Duration	Total Cost (lakh)
1	Exchange programme by External Expert and Consultants	15000	32	12(months)	4.80

#### Prevention of disability in leprosy cured persons through Homeopathic Medicine

As Chhattisgarh is leprosy endemic state, it is likely that there is a large number of leprosy patient existing in the state and the proportionate rate of Multi bacillary leprosy. Prevention of disability is an integral part of the National leprosy elimination programme which remains unsuccessful. The cases suffering from nerve impairment will be in large number. The clinical research undertaken in the Homeopathic medicines so far recorded a remarkable success in the treatment of plantar ulcers and nerve impairment in leprosy cured persons who have been suffering from residual effects like Chronic Ulcers ,peripheral anesthesia and other secondary complications. National Institute of Homeopathy has recognized the activities by



the organization. To prevent the complications the Homeopathic medicines shall be needed on pilot basis in two districts(Janjgir Champa and Korba),conduction of training programme for creation of awareness of Leprosy and the curative aspects of Homeopathic medicines. Setting up referral facilities in Janjgir Champa for the patients who need further treatment in the higher centers of the state.

S.NO	Unit Description	Unit cost	No of units	Duration (months)	Total Cost (lakh)
1	Homeopathy Consultants	20000	4	12	960000
2	Paramedical Staffs	8000	12	12	1152000
3	Social Workers	3000	10	12	360000
4	Project Coordinator	25000	1	12	300000
5	Establishment of Referral Unit	800000	1	1	800000
6	Cost for Training	510000	1	1	510000
7	Travel, Conveyance and Contingency	400000	1	1	400000
	Total				44.82

#### NATIONAL CONSULTATIVE WORKSHOP FOR CREATION OF ROAD MAP OF AYUSH MAINSTREAMING:

Mainstreaming of AYUSH needs to be major strategy for uniform service provision at all the allopathic centers with complementary care. This activity of co-location and development of AYUSH centers in allopathic units needs to be planned by computing the needs. This planning needs a consultative workshop of AYUSH doctors in activities under taken by NRHM and addressing the needs of the physicians. First workshop for computing the needs of health care institutions in Chhattisgarh, second workshop is envisaged for a detailed planning on the mainstreaming component. The third round of workshop needs to be undertaken for preparation of road maps for the activities undertaken in NRHM for mainstreaming AYUSH. For workshop of 16 District Ayurveda Officers and 6 members from the State for the planning board and execution of mainstreaming component, with involvement of external experts for mainstreaming as 8 members (total 30 members) for computing needs, detailed planning and for preparation of road map for AYUSH mainstreaming and selected physicians of dispensaries need to be trained for implementation of road map at the specific districts. At every district level four physicians are selected to be trained for the successful implementation of mainstreaming component at all the districts.

The training component added in the budget of 2009-10,this budget shall be reappropriated for innovative studies to be conducted in the state of Chhattisgarh for AYUSH Component. This study shall be conducted by any external agency for the Department of AYUSH.

S.NO	Unit Description	Unit Cost	No of units	Duration	Total Cost (lakh)
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1	Workshop for Dist Ayurveda officer/State implementers and External experts	5,00,000	1	3	15.00
2	Innovative study for mainstreaming activities	50,000	15	1	7.50
3	Documentation and publication	1,00,000	1	1	1.00
	<b>TOTAL</b>				<b>23.50</b>

### **AYUSH Technical Assistance**

The salary component of AYUSH Technical support, finance assistance and programme assistant has been included in the corpus fund of State Health Resource Centre and the fund allocated for mobility support for the programme coordinators has unspent balance of 11,50,000 and the fund for external experts cost 1,50,000 and this needs to be reappropriated for the mobility support of programme coordinators in the year 2010-11

### **AYUSH TRAINING FOR ANGANWADI WORKERS**

As a major intervention of mainstreaming the Department of AYUSH has included the training of ASHA in AYUSH based principles, this training has already completed in the State of Chhattisgarh as training of Mitanni's for Propagation of AYUSH preventive principles and home remedies as herbal treatment. As an innovative strategy the department of AYUSH needs to train the Anganwadi workers working for Mother and Child Health and the ANM'S who are the grass root level health care providers in Allopathic units. The Anganwadi workers can enhance the child nutrition and Maternal Health by the AYUSH herbs. These ANM's and Anganwadi workers can propagate the AYUSH based preventive principles and herbal remedies for common public. The module for the training has been developed and the TOT to be completed by march 2010. The field level training by the TOT for the Anganwadi workers needs to be reappropriated to the budget of 2010-11.

### **Additional Manpower for tribal CHC and PHC**

S.NO	Unit Description	Total participants	No of Days	Per day cost	Total Cost (lakh)
1	Training Anganwadi workers	35,000	2	125	87.50
2	Training material	35,000	1(Unit Cost)	50(per module)	17.50
	<b>Total</b>				<b>105.00</b>

The additional man power for tribal and remote areas had been put in the PIP 2009-10. The recruitment process has been initiated and the AYUSH pharmacists will be placed in the Tribal CHC and PHC by the end of January 2010. The salary expenditure will be spent for two months for the year 2009-10 and the rest amount needs to be reappropriated for the



**budget of 2010-11 and the programme shall be continued for the financial year 2010-11. Rest amount sanctioned for 52 Centers shall be surrendered.**

S.NO	Unit Description	Unit Cost	No of units	Duration (months)	Total Cost (lakh)
1	Man power for CHC&PHC	6,000	100	12	72.00
	Total				72.00

**Note:** The highlighted budget head is carry forward from 2009-10 to 2010-11

### SICKLE CELL ANEMIA

Sickle cell anaemia is a genetic disorder and is a lifelong disease. It is known to be prevalent in certain specific castes in Chhattisgarh. The actual estimates are not available. The diagnosis of sickle is based on the electrophoresis test. The reliable estimate on the load of disease is not available.

In case of sickle cell anaemia, the solubility test is conducted for the screening of the cases. The positive cases should undergo the electrophoresis test for the diagnosis of the sickling.

This year it is been decided that this solubility test will be conducted for the high & higher secondary school students of the selected districts, namely Bijapur, Dantewada, Bastar, Narayanpur, Kawardha, Rajnandgaon & Sarguja The total number of students which will be covered for this screening test will be around 4.5 lakhs. This will help in having the estimates of the prevalence of sickling in this population.

This screening test will be done with the help of sickling diagnostic kit. The cost of each test will come around Rs. 10/- per test. So, overall cost of the investigation will come around 5 lakhs of rupees. This test will be carried out in the high & higher secondary schools of the selected districts. For this work the lab technicians posted in the govt. Public Health Institutions (PHI) will be utilized. They will be given basic training in conducting this test. It is envisaged that the work force present in the PHI's will be utilized and for this their capacity building will be taken care off. This will only add value to the overall capacity of the PHI.

The positive cases will be then taken for the electrophoresis to pick up the person suffering from the illness. Such identified cases will be given sickle cell anaemia kit which will have Tab. Folic acid, literature on sickle cell anaemia.

### OBJECTIVE:

Screening of high & higher secondary school students from seven selected districts

### STRATEGY:



The sickle cell cases will be identified among the high & higher secondary school students. As a pilot project it has been decided that it will be carried out in seven selected districts this year.

#### ACTIVITIES:

1. One of the medical officers from the district will be the nodal officer for the project.
2. Under his guidance the lab technicians in the district will be responsible for carrying out the screening test for sickle cell anaemia with the help of rapid diagnostic kit. For this they have to visit all the high & higher secondary schools in the district.
3. The identified positive cases will be taken up for the electrophoresis.
4. These ICTC counsellors will be given training on the sickle cell anaemia.
5. The sickles so confirmed will be provided counselling by these ICTC counsellors.
6. Each of these cases will also be given a medicine kit having tablet folic acid, literature on sickle cell anaemia.
7. The blood grouping for all the cases found positive in the screening will also be done.

#### Action to be taken:

Positive Cases will be taken up for electrophoresis & counselling to deal with the disease. For counselling, ICTC counsellors will be utilized. Even they will be given exposure for the counselling skills.

S. no.	District	No of students in		
		High school	Higher secondary	Total
1	Bijapur & Dantewada	9339	8583	17922
2	Narayanpur & Bastar	20127	12671	32798
3	Kawardha	15288	5294	20582
4	Rajnandgaon	40297	14283	54580
5	Sarguja	146300	12500	158800
Total		231351	53331	284682

#### **Budget estimate for the sickle cell**

Table II: anaemia

Number of students	Cost of screening test	Incentive for the counsellors	Capacity building of Lab Tech & Counsellors	IEC expenses per block	Cost of electrophoresis	Total cost
284682	4270230	70000	186000	116000	400000	5042230

284682 students will be covered under this project in seven districts. The total cost is Rs. 50.42 lakhs.



## B9 IEC-BCC NRHM

### B9.1 Health Mela

Apart from the routine / regular services at facility level there is requirement of camp based services in rural and tribal areas, due to lack of adequate staff and transport facility. There is assembling of people during the weekly days of Haat Bazaar and other occasions of social gathering. Taking consideration of these opportunities, to improve the coverage and quality and services, Health Mela will be organised. The Mela will provide health care services along with awareness and information at the doorsteps of the people for promoting preventive, curative and rehabilitative services. The health Mela will have the following components:

- Adequate publicity will be undertaken before organising the Mela.
- Physical check of those who report at the Mela / camp especially, eye, ENT, dental etc.
- Investigations like common pathological investigations like blood sugar etc. Will be carried out.
- For each of the Mela adequate number of medical specialists, surgeons, gynaecologists, ENT specialists, Eye Surgeons etc. Will be drawn from local government health institutions, private doctors and IMA.

### Budget

S. No.	Level for Health Mela	Unit Cost	No. Of Units	Total Cost (lakh)
1	PHC Level	2000	716	14.32
2	Block Level	10000	144	14.40
3	District Level	100000	18	18.00
Total				46.72

### Mobile Medical Unit

In the state of Chhattisgarh where the population density is quite 154 per sq km. and the habitation is quite disperse dispensing health services is a challenge. In order to provide basic health facility to these under served and unserved area the state need to take help of mobile health clinics. In the year 06-07 Gol has given funds to procure such vehicle which will house one examination area , one lab testing area, one drugs dispensing area and one staff vehicle. State is in process of procuring such vehicle. These vehicles will have two doctors (contractual) staff nurse, lab technician and one pharmacist as medical unit and in non medical unit one supervisor and two drivers. This unit will be made operational by mostly by contractual staff and Local NGOs who will help to organize family planning camps for male, minor operation, malaria checkups, follow-ups, etc. For operational purpose each vehicle will



be issued untied fund of Rs 5 lakhs each in every quarter and will be asked to organize three camps per week.

The budget proposed for this project already been sanctioned in the previous year 2007-08 PIP and one prototype MMU has been reached to state and other MMU are under manufacturing, so the unspent balance of **Rs. 782.72** will be used during this financial year 2010-2011.

## **B12 Additional Contractual Staff (Selection, Training, Remuneration)**

### **B12.4 RMA: Utilising the 3-Year Rural Medical Training Assistant**

Chhattisgarh, like most of the states in India, is facing severe shortage of medical personnel to serve in rural areas especially the tribal and remote areas. Continuous efforts made by the state government to get adequate number of doctors posted in these areas failed. In tribal areas, we have permission to appoint Ayurvedic Doctors (BAMS) but their availability is also limited. Consequently, 1400 doctor's posts are vacant across the state.

Considering this, in last year's PIP, the state proposed that provision be made to appoint three-year Rural Medical Assistants the state government run and designed RMA course. The state proposed that these 'Practitioners in Modern and Holistic Medicine' be placed (only) in Primary Health Centres as 'Rural Medical Assistant'. The plan also included post-appointment induction training of 3 months in District Hospitals and Community Health Centres, in order to ensure adequate exposure of RMAs to clinical services and national health programmes.

At present, total 858 posts are filled through two consecutive counselling's. These Rural Medical Assistants have been placed at PHCs in tribal and remote blocks of 18 districts.

**Table: Status of RMA Posting**

<b>Status of Rural Medical Assistant</b>				
<b>S. No.</b>	<b>Name of District</b>	<b>Appointed before Oct 2009</b>	<b>Appointed in Oct 2009</b>	<b>Total</b>
1	Kanker	25	11	36
2	Jagadalpur	40	25	65
3	Jashpur	22	17	39
4	Koriya	22	9	31
5	Rajnandgaon	27	25	52
6	Bijapur	8	9	17
7	Sarguja	1	95	96
8	Korba	31	11	42



9	Narayanpur	7	2	9
10	Dantewada	9	22	31
11	Kawardha	4	22	26
12	Raigarh	33	26	59
13	Raipur	0	81	81
14	Bilaspur	0	84	84
15	Durg	0	86	86
16	Dhamtari	0	26	26
17	Mahasamund	0	30	30
18	Janjgir - Champa	0	48	48
	<b>Total</b>	<b>229</b>	<b>629</b>	<b>858</b>

This year, the state proposes to further increase the number of posts of RMAs to five hundred. A TOT for Induction training of Rural Medical Assistants will be organised. These trainers in collaboration with other district and block level trainers will train these rural medical assistant in respective District and Block hospitals. The recruited RMAs will work under the supervision of medical officer for better performance of PHC.

S.N.	Area of Positioning	Unit Cost	No. of Units	Duration	Total cost
1	General areas	12000	858	12	1235.52 lakh
2	CRMC hardest areas	12000	150	6	108.00 lakh
3	LWE areas	12000	284	6	204.48 lakh
<b>Total</b>					<b>1548.00 lakh</b>

#### B.14 Training

##### B14.3.3 PHRN: capacity building in public health management of state, district and block

In the last few years, Chhattisgarh has been trying to build the capacities of Health Officials in Public Health Management under the NRHM vision. This has been done through within the State capacity building trainings and enrolment in Academic Programme both long distance and Institute based.



## 1. Capacity Building of 300 Health Officials in District Health Planning and Management through PHRN Distance learning Programme

Public Health Resource Network (PHRN) and SHRC are jointly conducting Fast Track sessions for District Health Managers in District Health Planning and Management under the PHRN Distance Learning Programme. This is being done in partnership with SIHFW, NHSRC and the State Health Mission. This initiative has been a part of the Chhattisgarh PIP since 2007-08. A total of 300 health officials are to be trained for 18 days divided into three rounds of 6 days each. As many as 279 participants from 18 districts have undergone the first round of this training and out of them, 72 persons have undergone the second round of training.

### Progress of Fast Track Capacity Building Programme (2009-10)

Month/Year	No. of participants	Rounds completed (out of 3 rounds of training)
March	27	1 <sup>st</sup>
April	19	1 <sup>st</sup>
June	18	1 <sup>st</sup>
July	32	2 <sup>nd</sup>
August	13	2 <sup>nd</sup>
October	13	2 <sup>nd</sup>
January		Proposed
February		Proposed
March		Proposed

This capacity building programme has covered participants from all the 18 districts. Specifically, District Program Managers and Block Program Managers from all the districts have attended the Fast Tracks. Participants also included CMHOs, Medical Officers, BMOs and District Nodal Officers. ‘

The Block Program unit under the NRHM came into being around September 2008. An urgent need was felt by the State Health Mission for capacity building of the Block Program Managers who are qualified MSWs and MBAs but with very little or no experience in health. Hence the 6<sup>th</sup> and 7<sup>th</sup> Fast Track batches included only the Block Program Managers and the training was specially tailored to their level and needs. They have also undergone the second round training.

Detailed composition of total number of participants is given below -



### Composition of Participants in Fast Track

S. No.	Designation	No. of participants
1	CMHO	3
2	MO	73
3	BMO	41
4	AMO	9
5	DPM	17
6	Civil Surgeons	2
7	DIO	2
8	DMO	3
9	DLO	5
10	DTO	2
11	DHO	5
12	DPHN	3
13	BPM	53
14	BETO	10
15	BEE	2
16	DDA	4
17	AYUSH	2
18	Asst. Professors	2
19	Others(civil society/NGOs/DHS)	41
<b>Total</b>		<b>279</b>

### Post Training Follow-up

An important element of the Fast Tracks is the post training follow-ups. The Fast Track participants have been involved at various levels, in the formulation of the District health Action Plan and the State PIP. Follow-up meetings have been held in Ambikapur, Bastar, Koriya, Raigarh, Rajnandgaon, Kanker, Mahasamund, Durg, Raipur, Dantewada, Bijapur and Kawardha Districts

In the year 2010-11, the second round of the remaining participants will be completed and the third round will be initiated.



## 2. Post Graduate Diploma in District Health Management with IGNOU

Indira Gandhi National Open University (IGNOU) in collaboration with PHRN has started a new course Post Graduate Diploma in Public Health Management (PGDDHM) in June 2009. This course will help in building competencies in one of the core strategies of NRHM which is decentralized planning. PGDDHM has been recognized as relevant by NRHM in building capacities for decentralized planning and management at State, District and Block levels.

It aims to help committed individuals in the government and civil society groups in districts to build their capacities in health management and exchange technical resources towards strengthening the public health systems in their districts. This course is especially relevant for a state like Chhattisgarh where such opportunities are few.

In the 1<sup>st</sup> year (2009), NRHM Chhattisgarh has extended scholarships to 2 DPMs and 6 BPMs and intends to expand this number in the coming year. The contribution of NRHM will be 80% of the cost.

## 3. Post Graduate Diploma in Public Health Management/ Policy/Administration Course at IIPM

This course is a one year residential programme. Till date, 7 senior health officials have been enrolled for this programme. This course helps in building public health capacities for senior health personnel.

### Budget

SN	Programme	Number of Units	Unit cost	Total Amount
1	PHRN Distance Learning programme (2nd round for 100 participants and 3rd round for 250 participants)	350	9500	3325000
2	IGNOU PGDDHM	50	8000	400000
3	PGDPHM Course at IIPH	10	200000	2000000
	<b>Total</b>			<b>5725000</b>
	Previous balance Committed expenditure (Ongoing)			(-) 2260000
	<b>Fund required 2010-11</b>			<b>3465000</b>



#### B14.3.4 Career Development pathway for Health Staff (ANMs) and Mitans

##### Rational

In Chhattisgarh more than 59000 Mitans as community health volunteers (CHVs) leading their helmet since 6 years. During this time period their competence (knowledge, skill, attitude) has been developed on different topics like child health, maternal health, first contact curative care, local herbal remedies, local health planning, management of neonatal and childhood illnesses, home based neonatal care, infant and young child feeding practices, women empowerment, behaviour change communication etc. Their work has shown a visible impact on reduction in infant mortality and other key behaviors viz. early and exclusive breastfeeding etc. **It has been found that almost more than 4000 CHVs are 10<sup>th</sup>/12<sup>th</sup> pass.**

In contrast to this community effective involvement, our state is facing a great paucity in availability of staff nurses, ANMs, GNMs. One side state capacity is less in developing the new ANMs, GNMs etc. on other hand the available nurses are more interested to go outside the state or to join private institutions. Taking this opportunity of available proficient community health volunteers and weakness of lack of nurses in the state, along with the NRHM architectural revival of health system, a provision has been made with needful fund allocation in NRHM state PIP 12009-10 to give chances and priority to MITANIN-CHV to become Staff Nurse/ GNM/ ANM by prescribed courses in government and private colleges. State government has taken a most important decision that not only CHV will be given opportunity but also Mitans trainers and district resource persons of the Mitans Program will be sponsored for the courses of staff nurse/ANM/GNM.

##### Process-

After receiving the ROP for NRHM state PIP 2009-10, in Aug 09 a state level motivation drive has been organized to mobilize all 12<sup>th</sup> pass (biology group) Mitans to appear in a written entrance test organized by a group of private nursing college affiliated to department of medical education, government of Chhattisgarh. More than 125 Mitans has been appeared in this exam and 55 Mitans has been exhibited her calibre as successful participant. **State Health Resource Centre (SHRC) has facilitated the whole process of listing, motivation, screening, counselling and admission to colleges, in close coordination with department of medical education and NRHM CG.**

##### The commencement of new journey-

As a result of above process total 24 Mitans, 10 Mitans trainers and 4 district resource persons of Mitans program has been finally recommended for 4 year course of B.Sc. Nursing to NRHM by SHRC. Currently out of these 37 exactly 35 has been taken admission in different



private nursing colleges of the state. For each one NRHM CG has been supported a yearly amount of sixty five thousands to take responsibility of their food, hostel charges etc.

S. no.	Selected Participant from	No of participants who has taken admission and studying in Private Nursing College
1	Mitanins	23
2	Mitanin Trainers	10
3	District Resource Person	03
4	Total	35

Ultimately their study has been started and a new era commenced in saga of community health volunteer. Continuous hard works of last six year resulted in to the blooming beginning. Same time a lesson also learned that a close hand holding will be required to support these Mitans to complete their four year course timely and successful. SHRC is instrumental in hand holding of them, which currently managing their key problem of English language (which is medium of course in all colleges).

#### Plan-

State is planning to facilitate more **CHV/ Mitans** to take courses of ANM/GNM in coming year of 2010-11. These more than 4000 skilled and experienced CHVs will get opportunity to get sponsorship of these courses from state as per follows

To strengthen the existing nursing capacity of Chhattisgarh further, another strategy is suggested. Under this strategy, **ANMs** working with the public health systems for at least 3 years will be promoted for higher studies of General Nursing and Midwifery (3-year course) / BSc course and thereby qualified for Nursing Staff, under this scheme. In first phase 30 ANM wills would be selected. The selected ANMs will be sent either to public or private nursing institutes for this course.

#### Selection Criteria for ANM

- Must have in service, in the capacity of ANMs for at least 3 years or more.
- Must not be aged over 35 years
- Must have received formal education at least up to 10 +2 Standards
- Must had had biology as a compulsory subject during 10+2 studies
- Willing to serve the state for next 5 years after completion of the course.



### Selection criteria for Mitadin

- All Mitadin completed 12 rounds of trainings or the latest round of training organized in her block will be eligible.
- In the above rounds of training 5<sup>th</sup>, 7<sup>th</sup> & 10<sup>th</sup> is a minimum must for selection.
- Area wise priority-hardest and hard areas under CRMC will get priority in that order over general areas for selection.
- After considering the above three criteria merit (% of the 10<sup>th</sup> class marks) will form the basis for selection.
- Reservation for SC, ST & OBC Candidates will be followed as per govt. rules.
- While considering area wise priority the candidate from areas with govt. Health Sub-Centre building lying vacant for ANM appointment more than 2 years will be given priority.

Note - 10% additional candidate list (of 30) will be prepared as reserve list for substituting drop out candidates.

Table:

S. No.	Category	GNM / B. Sc. Nursing Course	ANM 18 month course
1	Mitanins, Mitadin Trainer, District Resource Person	20	360
2	ANM	30	00
<b>Total</b>		<b>50</b>	<b>360</b>

### Budget Required

Category	Unit cost	No. of unit	Budget
B.Sc. Nursing ( Fees for previous Year selected Mitadin )	35	70000	2450000
B.Sc. Nursing ( for current year )	25	70000	1750000
<b>Total – A</b>			<b>4200000</b>
ANM	360	55000	19800000
Counselling meeting (25 participant in one meeting)	14	12500	175000
<b>Total – B</b>			<b>19975000</b>
<b>Grand Total ( A+B)</b>			<b>2,41,75,000</b>



## B.16 Incentives Schemes

## B.17 Planning, Implementation and Monitoring

### B.17.1 Community Monitoring (Visioning workshops at state, Dist, Block level)

Community-based Monitoring of health services is a key strategy of National Rural Health Mission (NRHM) to ensure that the services reach those for whom they are meant, especially for those residing in rural areas, the poor, women and children. Community Monitoring is also seen as an important aspect of promoting community led action in the field of health.

The provision for Monitoring and Planning Committees has been made at Primary Health Centre (PHC), Block, District and State levels. The adoption of a comprehensive framework for community-based monitoring and planning at various levels under NRHM, places people at the centre of the process of regularly assessing whether the health needs and rights of the community are being fulfilled.

Community monitoring is to review the progress to ensure that the work is moving towards the decided purpose, and the purpose has not shifted, nor has the work been derailed in any way. Such a review can help to identify obstacles in the work, so that appropriate changes can be made to cross the obstacles.

#### Current Status:

In the Pilot Phase in Chhattisgarh, Community Based Monitoring of health services was implemented in 3 blocks each in districts of Koriya, Kabirdham and Bastar.

#### Project Area for Community based monitoring pilot 2008-09

Districts	Blocks	PHCs	Villages
Koriya	Khadgawan, Manendragarh, Jankpur	09	45
Bastar	Tokapal, Baastanar, Darbha	09	45
Kabirdham	Kawardha, S. Lohara	06	30
03 Districts	09 Blocks	24	120

#### Objectives

- To ensure regular and systematic information about community needs, which will be used to guide the planning process appropriately
- To provide feedback according to the locally developed yardsticks, as well as on some key indicators.



- To provide feedback on the status of fulfilment of entitlements, functioning of various levels of the Public health system and service providers, identifying gaps, deficiencies in services and levels of community satisfaction, which can facilitate corrective action in a framework of accountability.
- To enable the community and community-based organizations to become equal partners in the planning process. It would increase the community sense of involvement and participation to improve responsive functioning of the public health system. The community should emerge as active subjects rather than passive objects in the context of the public health system.
- Community monitoring will also be used for validating the data collected by the ANM, Anganwadi worker and other functionaries of the public health system.

### **Key Strategic action**

- a) Strengthening of VHSC (along with Mitadin as convener in it) will be effective for community level monitoring. Some of the important monitoring results will come out in a form of VHP.
- b) Formation of PHC/CHC/DH level Monitoring and planning committees.
- c) Mitadin Help Desk (MHD) will also be used as Community Monitoring desk
- d) We will develop roles of Zila or Janpad panchayat Standing Committee in it. The involvement of Zila/Janpad panchayat Samitis will open an opportunity for the inclusion of community representatives in structured and manageable manner. With this it will also compliment NRHM guideline on decentralization and participation of various local bodies
- e) Public health persons will be assigned some villages, sectors or blocks as per the strength for monitoring / planning of the services. The existing human resource in blocks and districts will also be used for this

### **Activities**

The following activities will be undertaken-

- Strengthening of State Planning and Monitoring Committee
- Replicating the pilot basis community base monitoring of health services in rest 18 districts
- Implementation of the above Community Monitoring Framework in the selected districts.
- Ensuring the village level monitoring through Mitadin cascade of MT/DRP
- Ensuring the formation and use of monitoring committees for Community monitoring
- Using public health experts as mentors for community monitoring



- Ensuring the Zila /Janpad Panchayat related platform for community monitoring at district level

Regular meetings of the Monitoring committees need to take place even beyond the project period. It is expected that after the project period, the need for such meetings will emerge from the committee members themselves and this activity will go on as part of the VHSC process.

**The above activities will be carried out with facilitation support from SHRC.**

### Indicators

- No of Monitoring Committee formed at district/ block/PHC
- No of meetings and dissemination events at all levels
- No of Village Health Plans used for advocacy at PHC/block/Zila level

### Budget for implementing Community based Monitoring in 18 districts (1 Block per district)

**Table 3.35: Budget Summary for implementing community based monitoring in 18 districts (1 Block per district)**

Sl No.	Strategy/Activity	No. of Unit activity	Participants in each unit activity	Cost per activity	Total Amount
<b>Block Level</b>					
1	<b>Orientation of members of community monitoring</b>				
	Block	1	20 members per block committee	5000	5000
	PHC	all	10 members per PHC committee	10000	10000
	Villages	all	3 VHC members per village		
	Block Provider Orientation	1	40 participants from Health dept, ICDS, PHED etc	10000	10000
	Sub-Total (A)				<b>25000</b>
2	Gathering data and report		Data gathering on availability of health services by committee members through Village meetings, group discussions and facility survey		
	Village data gathering and report	All	Formats to be printed		



2005-2012

	PHC/CHC/DH data gathering and report	all	Formats to be printed		5000
	Sub-Total(B)				5000
3	Regular Meetings of Monitoring committees and dissemination of monitoring report				
	Meetings Survey Dissemination	1		35000 per Block	35000
	Sub-Total(C)				35000
District Level					
4	District Facilitation, training of trainers				
	District workshop – Introducing concept to stakeholders and Orientation of District monitoring committee	1	50 participants	20000	20000
	Sub-Total (D)				20000
	Per District budget Total (A+B+C+D)				85000
Total 18 Districts (1)					1530000
State level					
3	State level workshop	1	30 participants for 2 days		50000
	State level Training of trainers	1	25 participants for 5 days		60000
	State level facilitation	12	State level coordination 20,000 @ and SHRC will facilitate and provide mobility support		240000
	State level budget Total (2)				350000
	Total Budget for 2010-11	Sum Total of- (1+2)			1880000



## B.19 Monitoring and Evaluation / HMIS

Objective	Strategy	Activities
<ol style="list-style-type: none"> <li>1. Well informed health system leading to timely interventions in a better way.</li> <li>2. To make an overall judgment about the effectiveness of programmes, often to ensure accountability.</li> <li>3. To generate knowledge about good practices developed during the implementation of NRHM.</li> </ol>	<ol style="list-style-type: none"> <li>1. Strengthening of M&amp;E System by using latest IT applications.</li> </ol>	<ol style="list-style-type: none"> <li>1. Printing of new forms and register to capture integrated data.</li> <li>2. Online application development for HR ,infrastructure, and Monitoring reports</li> <li>3. Computerization up to PHC level.</li> <li>4. Training of staff in new MIES</li> <li>5. Review meetings</li> <li>6. Field visits</li> <li>7. Web Base information management System</li> </ol>

Monitoring is a continuous management function that aims primarily at providing programme managers and key stakeholders with regular feedback and early indications of progress or lack thereof in the achievement of intended results. Monitoring tracks the actual performance against what was planned or expected according to pre-determined standards. It generally involves collecting and analysing data on programme processes and results and recommending corrective measures.

Evaluation is a time-bound exercise that attempts to assess systematically and objectively the relevance, performance and success, or the lack thereof, of ongoing and completed programmes.

Chhattisgarh state has made significance progress in lunching a web based Health MIS leading to transparency, speed and efficiency of capturing transmitting analysis and use of data for better health service delivery. For this use of NIC technical assistance with newly recruited programmers along with supply of hardware up to PHC level and formats and registers at lowest level of Sub Centre and village were the critical step taken.



## Activities

### 28. Printing of new forms and Integrated data capture register

- For beneficiary wise maternal and child tracking, village wise new integrated MCH register have been designed and printed which includes all the data elements of HMIS reporting format till sub centre. This will reduce the number of registers in the sub centre and also improve the sub centre level reporting system.

### 29. Online application development

- To fulfil the state specific requirement regarding review of programme implementation like Human resource, Infrastructure, monitoring reports etc. Four Programmers has been appointed @Rs.18000/- per programmer to develop all these requirements with the help of NIC, Chhattisgarh.
- Online daily monitoring reporting system has been started from District Hospital and CHC. The TOT was held at state level. Subsequent training was held at district level. The data entry of the District Hospital started in August 2009. The CHC level data entry started from Sep. 2009.
- On-line monitoring formats entry have been developed wherein the Officers posted in the State, District and below levels can visit the institution and fill in the formats of CHC/PHC/SHC and VHND formats.
- Infrastructure MIS – the data entry formats are being developed to capture the information related to how many centres are running in government buildings and other information of availability of labour room, toilets etc.
- Manpower MIS - the data entry formats for the personnel employed in each of the institutions, and their basic information related to place of posting the pay scale etc. provision is made to capture the information related to transfer and promotion of the employees.

### 30. Computerization up to PHC level

- In 2010-11 all the PHC will be computerized. A proposal of 370 more Desktop computers to be purchased and supplied to all PHC Rs1.85Cr @50000/-per Desktop computer is proposed. In all the PHCs one Data Entry Operators will be posted @6000/- total Rs. 5.1552 is proposed for 716 PHC.

### 31. Training of staff in new HMIS

- In current financial year all staff person related to Data reporting system beginning from PHC to State level will be given training on HMIS. The training on DHIS2 & HMIS Sub-Centre level format data entry training will be given to all the NRHM District and Block level staff. To capture the beneficiary wise information,



a Desktop ANM Register capture software is being developed. In the later stages the desktop data will be transferred to the On-line web portal. Entry in this software will be done at all the PHCs where computers have been provided. The other centres where there are no building and computers the entry would be done in the nearby PHC or CHC. Budget of Rs.500,000 lakh @500/- per person for 1000 computer personals is proposed in this financial year. Specialized skill up gradation training on monitoring and data analysis tools like SPSS, GIS etc. the proposed budget for 20 persons from the state and district level officer @ 20,000 per person. The requested budget is Rs. 400,000/

### **32. Review meetings**

- For monitoring the progress of the activities monthly and quarterly meetings are to be conducted at the state, divisional, district and block level. State level review meeting are personally chaired by Hon. Health secretary and Mission Director, District level meetings are reviewed by CHMO, DHO, CS. Block level meetings are conducted by BMOs and sector level review meeting are taken by supervisors.

### **33. Field visits**

- Review of quality of service delivery and utilization etc through routine visits are the most important part of M & E. Monitoring formats at all levels from sub Centre to District Hospital are designed and implemented. Nodal officers are appointed at state level Joint Director / Dy. Director, at District level - CMHO, DPM and Programme officers and at Block level BMOs and BPM are designated as a nodal officer for monitoring activities. Also Nodal officers for each of the component of RCH activities/NRHM activities have been assigned the job to monitor the quality of service delivery and utilization including through field visits. Mobility support fund proposed under the Programme management administrative cost @2000/- per visit for 5 visits in a month for SPMU and State Nodal officers.

### **34. Web Base information management System**

- New web site for Health Department is designed in which all the important correspondence and guidelines will be incorporated and updated on a regular basis. All the demographic and statistical information of all the programmes have been uploaded. The information of state specific programmes information is also given. The National level newly started National programmes of RSBY and JSY have been given due importance. All the guidelines and instructions to the district and block level would be uploaded regularly.



### Estimated budget

Sr. NO.	Particular	No. Of unit	Unit cost	Total (lakh)
1	Purchase of Desktop computers	450	50000	225
2	HMIS orientation training to be held 3 times	1000	500	15
3	Specialized monitoring and data analysis training (SPSS, GIS)	25	20000	5
4	Laptop for DPM and Hospital Consultants	36	60000	21.6
	Total			266.6

### B.19 Procurements of Drug, Machinery, and Equipment

Procurement and logistics management is one of the important aspects in the NRHM for the supply of essential drugs/ equipments and other necessary goods. Essential drug list has been revised in year 2007 by the expert in our state and it would be revised in year of 2010-11.

As per essential drug list and Government of India programme guideline drugs to be procured. Around 90% of the budget will be procured by central procurement committee and remaining 10% budget will be purchased in small quantity by the local institution, subject to emergency.

Procurement of the drug will be done, as per the central purchase rule of the state by the department of health services. The e-procurement process is being used for procurement of drugs/ equipments.

Under the State budget regular procurement is being done to provide health care services and also amount to be needed for this year is **1000 lakh** as per following table to full fill the access of quality of services under NRHM.



**B22 New Initiatives/ Strategic Interventions (As per State health policy)/ Innovation/ Projects (Telemedicine, Hepatitis, Mental Health, Nutrition Programme for Pregnant Women, Neonatal) NRHM Helpline) as per need (Block/ District Action Plans)**

**B.22.1 Establishment of Chhattisgarh Medical Services Corporation (CGMSC)**

**Back Ground:**

Disease morbidity in Chhattisgarh increases the economic burden on the poor families. The report of WHO strongly states that the poor have no regular access to Essential Medicines in the third world nations –India and Africa. As per the census the distribution of Chhattisgarh's households by wealth Quintiles is quite skewed towards the lower wealth quintiles. Forty three percent of the households fall in the lowest wealth quintiles, with only 18 percent of rural household of rural areas falling in the three highest wealth quintiles. Inappropriate health financing systems for the pro-poor households of Chhattisgarh increases the financial burden of poor.

**Disease Burden in the State - implication for the Establishment of Ware Houses**

As per the survey conducted by the Commission of Macroeconomics and health, the major disease burden of the country is of the infectious diseases and vector borne diseases, Tuberculosis, Maternal and Child hood disease and non communicable diseases.

The Health outcomes in the State shall directly depend on the Health sector reforms and policy changes. The reform is Essential in the Drug Policy of the State, identifying the existing gaps in the medicine procurement system, by improving the stewardship and creating resources. The existing disease burden in the State has increased the demand of the Scarce and inevitable resource, the Essential Medicine in the State. Fortunately with all efforts under health sector reforms, State has already adopted EDL for the public health system in 2003, and revised it in 2007. Only challenge is that periodical review and updating of list. **The timely medicine supplies which are cost effective and efficacious shall depend on the Strengthened Storage and delivery system.** Identified disease burden of the state by sound Epidemiological study of the State shall indicate the, drug policy to be designed and the Storage of the Pharmaceutical products on the disease threat posed on the State.

**Irrationalized drug distribution:**

Improper /Irrational handling, storage and use of medicine have been a grave issue of concern in the State. Inappropriately dispensed medicine leads to wastage of scarce resources and wide spread health hazards, which leads to misuse of the precious commodity indispensable for saving life. Quality and safety of medicine is less in the low income countries which includes India. The Quality of Medicine to be supplied to the District Hospitals, CHC and PHC, shall directly depend on the effective storage system as per the type of medicine



being stored. Easy access to the medicine as per the aroused demand which are not predictable in cases of disease out breaks and adverse calamities, shall depend on effective Storage and distribution System ,which needs to be developed at the level of primary health services .

People of Chhattisgarh have been subjected to poor access to medicine as the resources are scarce and the drug procurement and storage system is haphazard. Strategies and methods need to be devised to create a strong medicine procurement and storage system to improve the medicine flow to the health care institutions.

To achieve the objective of a rational drug management system, abiding to the applicable laws of the state with regulatory requirements pertaining to the drugs and medicines a quality policy is to be adopted. The Protocol/Policy should aim at providing a systematic and uniform approach in the decision-making process relating to the procurement of essential drugs and supplies. In other words availability of quality drugs in the specified quantity at appropriate time and place at the most competitive price is aimed at.

#### **Proposed CGMSC:**

The policy also seeks to put in place an efficient economic system based on the guidelines of the Central Vigilance Commission for the procurement of goods/ services in a transparent manner. For all above, one systemic reform is needed which will work for the procurement and logistic / inventory management. The past experience of Tamil-Nadu state, where one corporation known as TNMSC (Tamil-Nadu Medical Services Corporation) is established for all, is one of the best practices to reduce the above mentioned gaps. Chhattisgarh State would like to establish CGMSC based on TNMSC model.

#### **Target Group:**

The target group are the general public of the state. The Total state population is 20.83 millions where the tribal's account to 6.62 million populations. The under privileged population of the state is 41% population (BPL card holders of the state) also cannot afford out of pocket expenditure on medicines. The poorest quintile about 4/5<sup>th</sup> cannot afford the costs borne on the medicines for the treatment of illnesses. CGMSC will develop storage system of drug in a systematic manner for availability of medicine to the poor people through the public health care delivery systems (CHC, PHC and District Hospitals).

#### **Objectives:**

- Increasing the supply of pharmaceutical resources, vaccines and biological in the primary health network.
- Preventing the suffering and preventable deaths occurring due to inadequate access to Essential Medicine



- Improving the storage ,creation of adequate resources and optimum utilization of drug
- Constructing and Developing Modern Drug Warehouses in the state and districts.
- Drug supply effectively monitored and implemented and made prompt as per the demand created.
- Good practices in drug manufacturing, regulation and quality assurance implemented
- Strengthening the Drug policy of the State.
- Improving the Quality of product and reduce the cost
- Improving the Inventory management and storage of product.
- To reduce the contamination and spoilage of medicines
- Products of doubt for the efficacy tested and efficiency proven.
- Preventing supply of spurious drugs and counterfeited drugs by creating strong Pharmaceutical Analysis team.
- Post surveillance of the medicine safety maintained and strengthened
- Rapid response initiated in the case of unpredictable Calamities and Epidemic outbreak.

### **Structure of Corporation-**

The state will develop the CGMSC. This Corporation will develop the **Head office** for procurement and handling of distribution of medicine, and 6 district ware house will be developed initially in strategic regional locations in identified place for storage and distribution of medicine to health facilities.

State office will have staff capacity of 45 and all district office together will have 36 staff. 6 district warehouses would be established for logistic and inventory management.

Mr. R. Poornalingam (IAS) Retd. Chairman, Task force, Procurement & Logistic Management, MOFW, Govt. of India had visited in the state for preparatory works of establishment of Chhattisgarh Medical Services Corporation (CGMSC) and highly recommended the feasibility & need of CGMSC.

1. It will have an Executive Committee which will meet at least once in three months. The quorum will be of 50% members. The presence of the M.D. will be essential.
2. Executive Committee will implement the decisions taken by General body and will function within its powers invested by General Body



3. *Executive Committee will handle the funds allocated for procurement process and the internal processing of the drug distribution system for medicine availability in the districts.*
4. *Monitoring Supply Chain and creation of an environment of transparency.*
5. *Monitoring the Quality of the product or medicine from the manufacturer or agencies.*
6. *Creating all possible means and measures to reduce the Drug wastage in the procurement channel.*
7. *Develop a modern infrastructural model which is capable for storing Drugs and medicines which shall minimize wastage.*
8. *Procurement costs to be minimized which does not reduce the standards of the drugs.*

#### **Activities:**

1. *Rationalizing the Essential drug list based on the standard treatment guidelines.*
2. *Quantifying requirement - State and District-wise.*
3. *Specify dosage size, primary and secondary packaging standards*
4. *Establish procurement policy and adopt national open tender (e – tendering).*
5. *Design and develop organogram for state/district drug ware house and procurement.*
6. *Creating adequate storage facility.*
7. *Designing the layout for State, District and CHC drug ware house*
8. *Creating EFFECTIVE communication system within the organization*
9. *Creating an EFFECTIVE distribution system in every district.*

*Train Pharmacists on warehouse management*

#### **Strategy of CGMSC**

##### **Monitoring and Evaluation:**

*The Computerized System will evolve the scientific statements for the effective planning and execution for Systematized procurement and supply system. The monitoring of the Drug distribution system needs to be initiated from the fore casting of the requirement processing of Tender notice to the management information system which handles Procurement/Logistics functions of health commodities.*

##### **Procurement Process and Distribution system:**

*Order placement induces the scope of malpraxis .The orders needs to be placed through a transparent computerized channel of processing bids. The Supply system is to be monitored*



by the computerized networking channel where the procurement process is to be centralized and distribution process is to be decentralized up to districts. The transactions need to be timely and reporting to competitors needs to be initiated at every level of the procurement process for transparency.

### **Ware House information system:**

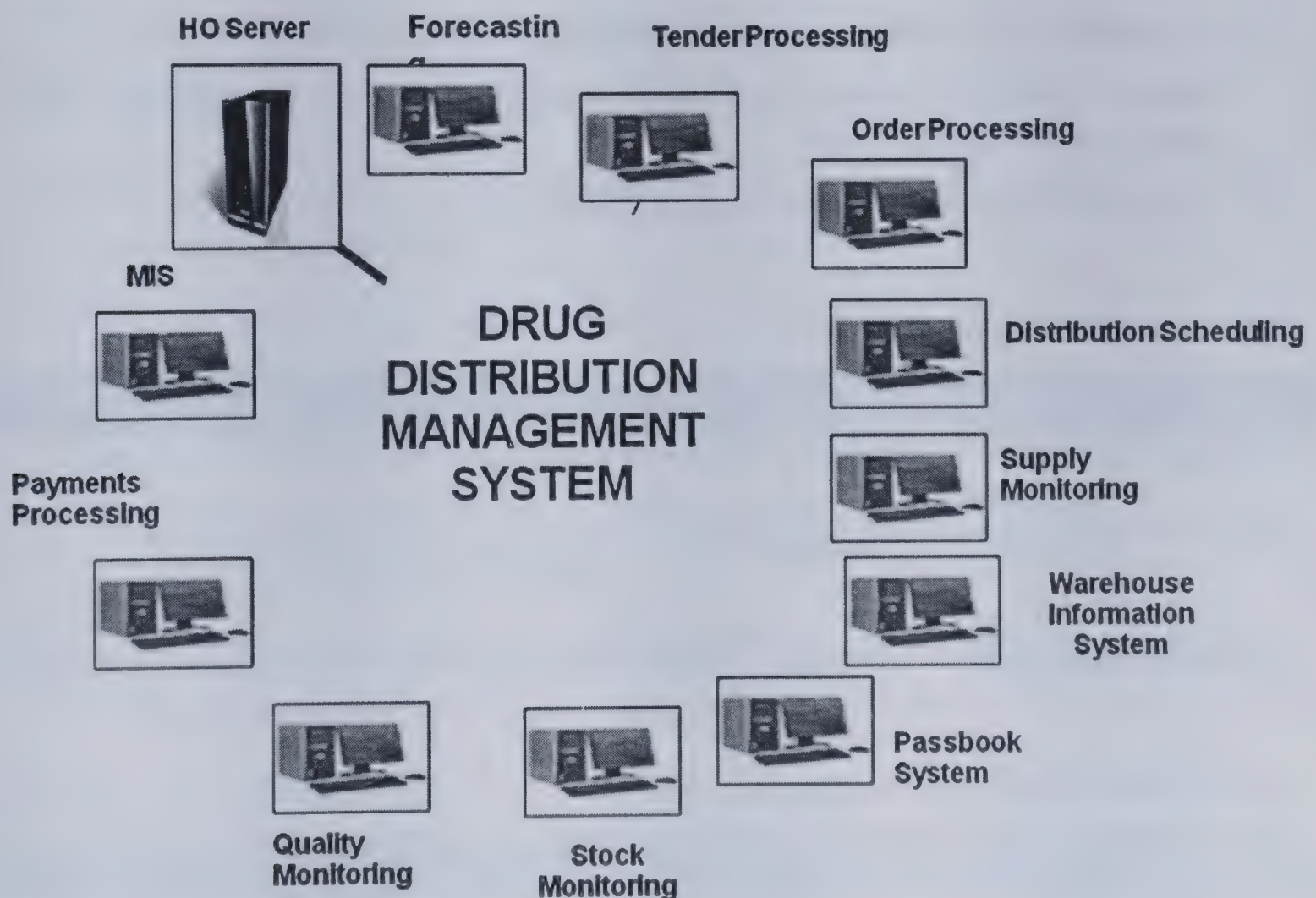
A soft ware needs to be developed as the Ware House Information system to provide micro details of the stocks in the warehouse including expiry dates the status of infrastructural facilities and the man power of the warehouse.

### **Stock Monitoring:**

Counter checking of the stocks monthly by strengthening stock verification system and monitoring by CGMSC.

### **Quality Monitoring:**

Analysis process of every sample entering the warehouse will be emphasised which creates a no compromise policy on the Quality of the Medicine. In case of any lapse in the medicine quality the supply agency is to be black listed to ensure the Quality of medicines.





### Output:

- Improved management of drug procurement and supply with special emphasis on logistics
- Improved Quality of product and reduce the cost
- Ensured continuous availability of drugs to all government health facilities
- Improved the storage, creation of adequate of resources and optimum utilization of drugs
- Sustained Drug policy and supply chain to the State.
- Upgraded skills of service providers in drug management and usage
- Maintain a key focus on human resource development.
- Centralized procurement of all drugs on essential drugs list of the state.
- Efficient distribution through decentralization at district drug warehouses
- Computerized information system to allow continuous monitoring of warehouse inventories.
- Improved Inventory management and storage of product
- Nullified supply of spurious drugs and counterfeited drugs by creating strong Pharmaceutical Analysis team
- Usage of the improved drug management system

### Project cost of CGMSC for one year

Head Office			District			In Rs.
Staff Salary	Office Expenditure (Fixed)	Office Expenditure (Variable)	Staff Salary for 6 District	Office Expenditure (Fixed)	Office Expenditure (Variable)	Total
9271920	3570000	6500000	4656240	47097600	26400000	97495760

### Estimated budget Total cost for 1st year

Particular	Total Cost
CGMSC Staff Salary	1.39
Fixed Asset for CGMSC	5.07
Funds required from NRHM	6.46 Cr



## Chhattisgarh Health Equipment Management Cell

### Background with current status-

To deliver good quality healthcare services, a large number of medical equipments, both diagnostic and curative, are required. Consequently, the medical equipments, often very sophisticated and costly, require proper management, right from planning to purchase and from use to condemnation.

A World Bank study shows in India, while 2-5% of district/town hospital budget is earmarked for "machinery and equipment," maintenance budget is merely 0.02-0.06% and rural health institutions have no maintenance budget at all, [World Development Report, 1994].

The findings of a study in this regard, conducted by the directorate of health services in Chhattisgarh, are quite revealing.

A large number of costly equipment is idle in many of the Health care institutions, Reasons:

1. Unaware about the existence of equipment.
2. Lack of Technical personnel who can handle the equipments.
3. Lack of annual maintenance contract (AMC).
4. Improper breakdown maintenance services due to lack of bio-medical engineers or other competent persons.
5. Transfer of in charge persons without completing formal handing over and taking over formalities.
6. Improper stock recording and no annual physical verification exercise in place.
7. There is no proper system for tracking of instruments from the place of purchase and distribution to the place of installation.
8. Payment is released on basis of inappropriate knowledge or inadequate reports and it is being certified by non-technical authority.

To solve these problems, we established "Chhattisgarh health equipment management system" (CGHEMS) in the last quarter of 2008-09. Infrastructure for the state office is also established with essential prerequisite. There are subsequently some specific outcomes in 2009-10. In 2009-10 it was supported by EUSPP programme, and the training component was budgeted in NRHM which was initiated but will be completed on year 2010-11.



## Objectives:

1. To facilitate functioning of a state level technical committee for procuring drugs and equipments in a transparent manner.
2. To ensure continuity of operations and services of institutions by maintaining a smooth functioning of the equipments and appliances.
3. To assist in need-based purchase of equipment at different levels.
4. To facilitate proper selection /of vendors and procurement of equipments
5. To help in developing terms of reference for annual maintenance contract for bigger and costlier equipments while arranging repairs for smaller ones at local level
6. To develop inventory management system for equipment & spares
7. Develop a web based online inventory management system for real time information on available stocks and regular consumptions of spares and consumables
8. Capacity building of personnel at different level for day to day management and operations of equipments
9. To ensure and supervise regular calibration of the equipments
10. To ensure proper and timely disposal of scraps and condemned equipments.
11. To develop a system for optimal utilization of equipments including plan for relocation, mobilizations etc.
12. To initiate Documentations – to inform authorities about the list equipments and appliances present in different institutions so that they can make appropriate use of them and do not raise requisition for additional equipments.

The funds available with Jeevan Deep Samiti under NRHM are inadequate to meet the investments and expenses that run in crores.

## Strategies/Plan of Action

1. Set-up of a Central Equipment Maintenance Cell at the state level serving as a technical body to the government of Chhattisgarh.
2. Set-up of District cells to cater to the needs of Districts.



3. *To establish a technical cell at state implementing annual maintenance contract to take care of periodical review of the performance of the vendors against their services.*
4. *Select and empanel a number of reliable, expert local vendors/contractors for repair works of equipments on call basis*
5. *Develop Standard Procedures for purchase, tenders, installations, maintenance etc.*
6. *Develop inventory control system for drugs, equipments and spares*
7. *Clean-up campaign for disposal of the condemned and obsolete equipments and appliances*
8. *Develop district level cadre for preventive maintenance.*
9. *Prepare a cadre of Technicians in Hospitals equipment repairs from facilities by arranging practical training at **Chhattisgarh health equipment management system***
10. *Fix a set of minimum performance parameter for technicians based on their qualifications and level of postings. This will help to evaluate their performance for providing incentives or disincentives.*

### **Expected Outcomes**

1. **Service delivery:** *Greater patient satisfaction from improved service quality and reduced out of pocket expenditure to patients for diagnostic and curative services, which they incur due to non-functioning machinery.*
2. **Financial:** *Increase fund utilization from optimized machinery life and reduced operating capital and expense*
3. **Documentation:** *for evidence-based planning and prevention of duplicate or inaccurate purchase.*

### **Achievement so far:**

*State has developed the Chhattisgarh Health Equipment Management System (CGHEMS) in 2009-2010 and the following tasks accomplished.*

1. *2 days training programme on X-Ray machines, Imaging equipment **and safety measures**, of 95 radiographer technicians have been completed.*



2. State level TOT has been completed with 45 Staff nurses on the essential equipment management, operation and utilization technique at periphery level.
3. 648 equipments have been repaired in the state with its own capacity upon request demand of hospitals.
4. System has located and identified the unused 30,000 equipment lying scattered in the state and recommended for relocation. Strategy for relocation is under process and would be undertaken.
5. Developed terms of reference for annual maintenance contract of equipment.

Modification in 2010-11: Every district will have CGHEMS unit with 2 technical assistants one for the district hospital and one for the periphery centres at the same time at state level there will be 3 engineers having expertise in biomedical, mechanical engineering or medical instrumentation.

#### Budget need for Operationalising Chhattisgarh Health Equipment Management System:

Manpower	No. of post	Pay Scale		
		Per month cost per unit	unit cost in a month	Annually (Lakh)
Chief Executive officer	1	35000	35000	4.2
Training Coordinator	1	20000	20000	2.4
Assistant Engineer*	3	22000	462000	7.92
Account Officer	1	15000	15000	1.8
Technical Assistant **	40	9200	368000	44.16
Accountant Clerks	1	7000	7000	0.84
Data operator	1	7000	7000	0.84
Store Keeper	1	7000	7000	0.84
Peon	2	4500	9000	1.08



Security	4	4500	18000	2.16
Office expenses	1	40000	40000	4.8
Computer with printer	3	50000		1.5
office furniture and fixtures, arrangement for training	1	400000		4
Mobility support for state unit	12	50000	600000	6
Mobility support at district level	18	100000	50000	18
Training (Details annexed)	8	230000		18.4
<b>Total</b>				<b>118.94</b>

*\*Engineers would be having qualification of Biomedical Engineering / Mechanical Engineering / Medical Instrumentation*

*\*\*Technical Assistants would be having ITI qualification & background on relevant subject with some practical experience.*

### **Proposal for Emergency Response Medical Services in Chhattisgarh**

#### **Business plan:**

##### **1. This scheme broadly envisages**

- Establishing an Emergency Response Centre (Call centre) and Emergency
- Learning Centre (A training centre to train paramedics, Emergency Medical Technicians (EMT), doctors of the state government).
- Obtaining a toll free 108 number from Government of India and establishing the connectivity with all the service providers of telephones and routing the calls through the designated place.
- Procurement, fabrication and equipping the ambulances with the required medical gadgets,



- Recruitment training and positioning manpower to operate the ambulances, emergency response centre and the supervisory staff at district and state levels.
  - Running the 24 hour Emergency Response Centre in 3 shifts with toll-free number "108"
  - Operating the 24 hour ambulance service in 2 shifts to cover Medical, Police and Fire emergencies
2. ERS can be introduced across the state of Chhattisgarh and the total project can be rolled out with in a time frame of one year [2010 – 2011]. However, the key factors for success of ERS in Chhattisgarh would be the availability of telephone connectivity (for **sensing** (communicating) the emergency), all weather motorable road connectivity (**reaching** the victim in time while providing pre hospital care) and hospital infrastructure at reasonable distances to be able to reach within 30 minutes (for providing **care** to the victim with in golden hour).
  3. Considering the existing functional hospital infrastructure and facilities and other key factors for success of the project, it is proposed to take up the project only in all the district headquarters and towns (including sub-urban and neighbouring villages) in 2010-11.
  4. The following are the capital expenditure (CAPEX) of the total project for rolling out the scheme in a period of two years. The operations expenditure (OPEX) in detailed in para no. 11.

S. No.	Component	Amount (crores)
1.	Emergency Response Centre (ERC) (Temporary set-up)	1.00
2.	IT Infrastructure	2.35
3.	Ambulances (38 nos.)	5.10
4.	Permanent ERC	6.06
<b>Total</b>		<b>14.51</b>



5. It is proposed to operationalise the ERS in one year as given below.

Year	Phase	Coverage	Population in lakhs	Ambulances	Schedule
2010 - 11		District Headquarters urban population including sub-urban areas and neighbouring villages (Jagadalpur, Bilaspur, Bade Bacheli, Dhamtari, Durg, Champa, Jashpur nagar, Kanker, Kawardha, Korba, Chirmiri, Mahasamund, Raigarh, Raipur, Rajnandgaon, Ambikapur)	31	26	Oct 2010 – Oct 2011
	IA				
	IB	All other towns urban population including sub- urban areas and neighbouring villages	15	12	
<b>Total</b>			<b>46</b>	<b>38</b>	

6. Out of total 38 ambulances only 12 (25%) will be **Advanced Life Saving Ambulances (ALSA)** and the rest 26 will be **Basic Life Saving Ambulances (BLSA)**. The cost of each ALSA is Rs. 17.53 lakhs and each BLSA is Rs. 11.53 lakhs. The total cost of all the 38 ambulances comes to Rs. 510.14 lakhs as per the prevailing market prices and the process will be done through open tender by state government. Each ambulance will cover a population of 1.20 lakhs approximately within a radius of 20 to 25 kms. The project will provide employment for 600 persons by end of Oct 2010 who will be mostly locals.
7. The implementation schedule is worked out considering signing of the MoU in December 2009. The initial estimated expenditure to create Emergency Response Centre, IT Infrastructure, procurement of 26 ambulances and operations costs for a period of six months in the year 2010-2011 is **Rs. 10.81 crores**.



The details are as follows:

S. No.	Component	Amount (Crores)
1.	Ambulances (26 nos.) - Phase IA	3.47
2.	IT infrastructure	2.35
3.	Temporary Office Infrastructure	1.00
4.	Operations (Oct 09 – Mar 10)	3.99
	<b>Total</b>	<b>10.81</b>

8. EMRI proposes that these services be run on a not-for-profit basis in Public Private Partnership (PPP) model with Government of Chhattisgarh where in the Government of Chhattisgarh will be funding the project and facilitate smooth implementation and shall provide complete operational freedom to EMRI in terms of recruitment of personnel, payment of wages and operational guidelines. EMRI would bring in the committed leadership, world class technology and innovation. EMRI would also provide need based training, conduct research and manage the operations through metrics driven approach to provide high quality Emergency Response Services in Chhattisgarh. At least 8 trips per day per vehicle in 3 years will achieve for cost effective utilization of ambulances. **The agency would be meeting more than 5% operational expenditure of the project.**
9. Every 3 months, the pattern of ambulance utilization will be reviewed by competent authority of state government for which a state Advisory Board with adequate representative of state will be constituted.
10. The linkages of accredited hospitals for Janani Suraksha, Rashtriya Swasthya Bima Yojana and EMRS/ Trauma will be established and the updated information will be provided to the concern authority and drivers for effective management of referral during the golden hours of emergency.
11. It will be mandatory for all the accredited hospitals / facilities to provide the free stabilization service for first 24 hours before referring to other facility. For which Emergency Medical Service Act will be enforce / amendment will done as per the requirement of state government.



12. Considering the challenges to operate the EMRI in the interior or rural area, hand holding will be done with the Mahatari Express so that the linkages to rural and interior area will be strengthen and very body will benefited equally.

13. In addition, EMRI provides the technological solution worth **Rs 20.00 crores** free of cost which consist of system integration of various IT components, customization and application software developed by Satyam Computer Services Ltd as the Technology Partner. The system of Emergency Response Services is operated through complex software that integrates many critical third party systems such as police and fire Emergencies for managing all emergencies in an integrated manner. The complex software automates all the activities of the Emergency Response Centre and supports activities of emergency handling such as medical assistance to critical patients, ambulance management, and equipment management.

14. . The estimated costing details is given below:

Period	Capital Expenditure	Operational Expenditure (95%)	Total (Crores)
Oct 10 – Oct 11	38 Ambulances	Salaries 1.12	12.33
	12 ALSA @ Rs 17.53 lakhs 2.10	Ambulance Running Costs 0.50	
	26 BLSA @ Rs 11.53 lakhs 2.99	Direct Operations Cost 2.37	
	IT Infrastructure 2.35		
	Temp ERC setup 1.00		
	Total 8.34	Total 3.99	12.33

15. The above amounts are indicative of the estimated costs. However, actual expenditure only would be claimed by EMRI. The entire physical infrastructure, movable and immovable assets and software acquired and created from the funds of Government of Chhattisgarh shall be the property of Government of Chhattisgarh.

16. To have a separate "Trust account "for this project which will lay to a "Board of Trustee ".



17. The detailed terms of references, the responsibilities of EMRI and the responsibilities of the Department of Health and Family Welfare of the Government of Chhattisgarh is given in the MoU which will be signed by both Government of Chhattisgarh and EMRI.
18. On signing of MoU, an advance amount of **Rs 8 crores** may be released towards the procurement of 38 ambulances, hardware, software, temporary ERC infrastructure creation and the operations cost as per the following schedule
  - Rs 5.00 crores on the date of signing the MOU
  - Rs 3.00 crores in the last week of Dec 09
19. The following are the steps involved in the process of rolling out the ERS in the state and we would need at least three months to launch the first batch of ambulances.
  - a. Signing of MoU between the Govt. of Chhattisgarh and EMRI.
  - b. Preparation the temporary infrastructure for locating Emergency Response Centre (which consists of a call centre and emergency response team along with other technology support.) at Raipur.
  - c. Procurement of ambulances along with required medical equipment.
  - d. Recruitment of the personnel for the state headquarters, regional and district level offices, pilots and Emergency Medical Technicians (EMT).
  - e. Training of the EMTs and the pilots on the technologies and skills involved in ERS.
  - f. Familiarization of the scheme to the personnel of medical, police, transport fire and other departments.
  - g. Training the doctors working in various government hospitals on their role in providing emergency care and skill development in emergency medicine.
  - h. Developing partnership with the private hospitals for admitting emergency victims and providing treatment free of cost for the first 24 hours.
  - i. Improvement of hospital infrastructure by the state government.



### **Budget estimated for year 2010-11**

In the current year NRHM needs to provide capital expenditure cost and 60 % of the operational cost so the estimated budget is

S. No.	Budge head	Proposed Budget (amount in crore)
1.	Emergency Response Centre (ERC) (Temporary set-up)	1.00
2.	IT Infrastructure	2.35
3.	Ambulances (38 nos.)	5.10
4.	Operations (Oct 09 – Mar 10)	1.80
	Total	10.25

The total requested budget in year 2010-11 is 10.25 cr.

### **New Initiatives for Mitnin**

For the year 2010 – 11 several new initiatives has been undertaken by the Government of Chhattisgarh, they are as following:

- Strengthening the **Mukhyamantri Mitnin Welfare Kosh**, formed by State government last year. Providing continuous support to eligible Mitnins- Insurance, relief in natural calamities including left wing left wing extremism and accidents, Eye check up and spectacles distribution etc.
- Providing an operational kit '**Mitnin ASHA strengthening package**' to all Mitnins. The operational kit is comprised of an umbrella, torch, Dawa Peti, raincoat, thermometer, slipper, and neonatal health check up 50 pages book on IMNCI etc. With the help of the kit she can easily deliver her task like home visit in rainy season, home visit during night hours and timely referrals
- Provision will be made for recognition of Mitnin in the existing health system by advocating for free health services to the Mitnin and her family in district hospitals/CHCs. Also, provide them the platform to enhance their self-esteem and to express their vision and mission of life.



- More than 7000 hamlets have been identified as new one on the population norm basis. In addition to the existing force **new Mitans** are to be trained to cover all the hamlets in state.
- Saluting their 7 years of volunteerism, a **career advancement has been worked out.** and progress, 10<sup>th</sup> and 12<sup>th</sup> pass Mitans, MTs and DRPs will be facilitated for BSc Nursing/ANM/GNM courses. At least 50 Mitans (along with Mitans trainer and District Resource persons) for BSc nursing and 300 for ANM.
- Ensure "**Mitanin Sammelans**" at PHCs level along with AWW/ANM to increase coordination. For improving coordination and referral cases management PHC level Sammelans of AWW, ANM and Mitans will be organised twice in a year at all PHCs.
- **Special social mobilisation** activities for the primitive tribes Mitans (These tribes are Abujhmaria, Baiga, Kamar, Birhor and Pahadi Korba.) in the state (district- Kabirdham, Raipur, Dhamtari, Korba, Jashpur). Special efforts need to be given to their capacity building through one-day orientation program in every quarter. Same way a special cluster meeting will be organised twice in a year of those Mitans who are also PRI members.(This activity would be done under tribal health/programme for the vulnerable population)
- Organising **Mitanin Diwas** every month at block/SHC/AWW level, in which the incentive distribution will be ensured through using a **Mitanin incentive pass book** for all Mitans under different national programs.

S. No.	Unit	Unit cost	No. of Units	Duration	Exp. per year
1	Mukhya Mantri Mitans Welfare Kosh	5000000	1	1	5000000
2	Mitanin ASHA strengthening package	500	60000	1	30000000
3	Training of 500 new Mitans( mobilisation,5 day training package, module)	2000	500	1	1000000



4	"Mitandin Sammelans" at PHCs (AWW /ANM/ Mitandin/ MO) 150 participant	3000	800	1	2400000
5	Special social mobilisation activities for the 500 primitive tribes Mitandins	150	500	2	Fund is proposed under another activity
6	Mitandin incentive pass book	25	65000	1	The activity will carried out from Mitandin programme contingency form.
<b>Total</b>					<b>384.00 lakh</b>

### **Parenteral Iron therapy**

In India, anaemia during pregnancy is a major health problem leading to maternal death. 63 % of the women in Chhattisgarh are anaemic as per NFHS 3, mostly due to deficiency of iron and folic acid. Out of which severely anaemic women are 5-10 %. Anaemia is directly or indirectly responsible for 20 – 30 % of maternal deaths and is associated with high perinatal loss.

Based on the haemoglobin content the severity of anaemia is categorised as following:

- 8.7 to 10 gm% - mild anaemia
- 6.6 - 8.6 – moderate anaemia
- 6.5 or less – severe anaemia

During pregnancy the iron demand is increased due to expansion of blood volume to meet the both maternal and foetal requirement. As prophylaxis we give 100 IFA tablets during pregnancy. With oral therapy the haemoglobin rises at a rate of 2 gm per month (approx) if the woman consumes the IFA tablet without interruption. The disadvantage of oral therapy is GIT intolerance in 10 % cases and desired Hb rise is unlikely to be achieved at the term, especially in those who come for check up in late pregnancy with moderate to severe anaemia. Between 16 – 26 weeks of pregnancy Hb% falls by 2% due to disproportionate rise in plasma volume (50%) compared to increase in RBC volume (30%).



To combat this moderate to severe anaemia iron-sucrose therapy in second trimester in conjunction with IFA tablets worth our consideration. With this therapy Hb% rises 3-4gm in a week (approx).

### **Route of administration**

Iron-sucrose is available in 2.5 ml and 5 ml ampoules. 3 ampoules of 2.5 ml in 100 ml normal saline can be given by slow IV infusion.

### **Budget**

The approximate cost of 1 ampoule of 2.5 ml is Rs. 132. We can target 5 – 10 % of severely anaemic pregnant women for this therapy.

There are approximately 7.42 lakh ANC population in Chhattisgarh, of which about 63 % are anaemic (NFHS-3). Of the anaemic ANC population, 25% are moderate to severely anaemic who would need this therapy, i.e. around 500000 populations. Iron sucrose parenteral therapy can be given safely as blood is not easily available everywhere.

Each of the beneficiaries would require 3 ampoules. Therefore, the overall cost for this activity is **225 lakh**.

### **Janani Suraksha Kit**

Pregnancy & Childbirth is associated with specific anatomical, physiological & immunological changes that can predispose to infection and also alter the response to the disease process. Infection demands prompt adequate and careful management. Some of infection may be serious & life threatening for the mother.

Puerperal sepsis is one of the major causes of maternal death and accounts for 15% of all maternal death. Puerperal sepsis can cause long term health problems such as chronic PID & infertility. It is extremely important for health personnel to be able to prevent puerperal sepsis & treat it promptly.

Puerperal sepsis is a bacterial infection of genital tract which occurs after the birth of a baby. It is usually more than 24 hours after delivery before the sym. /signs appear.

Some endogenous bacteria which are present normally in vagina without causing harm may become harmful and cause infection,

1. If instruments and hands are not clean.
2. In anaemic and malnourished woman whose resistance is low.

Some exogenous bacteria can be introduced

- By unclean hands and us sterile instruments
- By droplet infection, e.g. a health provider sneezing coughing on to own hands immediately prior to examination.



For prevention of these infections a concept of Janani Suraksha Kit seems to be a step taken ahead to prevent puerperal sepsis.

In Chhattisgarh – 50% delivery are conducted by ANM/LHV/SN in home as well as in SHC/PHC/CHC. The sterilization conditions are not up to the mark. Janani Suraksha Kit can be given to them; one kit for one delivery.

Contents of kit:-

1. Disposable mask, cap, 4 sterilized gloves (2 for p/v exam and 2 for conducting labour) Inj. Gentamycin for baby, inj. cefotaxim 1 gm for mother. 02 tablets Of misoprostol, 2 new cotton cloth (1 m. each) for wrapping the baby, one umbilical cord clamp, one infant suction tube, hand book of sanitary napkins and post natal care)
2. Kit contents will be provided by the State except misoprostol tablet and hand book.
3. The budget required for printing of hand books is **20 lakh**.

### **Use of Misoprostol for prevention of PPH**

Among the five major causes of maternal death topmost cause is post-partum haemorrhage. To combat this newer, method is introduction of 2 misoprostol tablets (200 micro gram) vaginally after delivery projected target of delivery for 2010-11 is approximate 7 lakh of which about 4 lakh deliveries are supervised for that 2 tablets will be required per delivery i.e. 8 lakh tablets. Per delivery 2 tablets will be required that means 14 tablets are required.

The required budget is about **80 lakh**.

### **Nutritional Support to PLHAs in Chhattisgarh State**

According to HIV Sentinel Surveillance Survey, the estimated no. of HIV positive people in the state would be 35000 – 40000. Out of these, nearly 3700 +people have been registered in the ART Centre Raipur, till December 2009. Nearly, half of these registered +persons are taking ART medicines. This figure is estimated to reach to 2500 approximately, by the end of FY 2010-11. Statistics suggests that every year 800-900 new +persons have started their ART treatment since 2007.

The no. of new registrations & On Art patients is increasing every month and this is to be noticed that most of the persons are poor or cannot afford their meal properly. Therefore, if they are provided nutritional support by us, it may not only support them to live a healthy life but would provide a mental support to fight against AIDS also.

Keeping this in mind, a brief proposal to provide Nutritional support to the infected ones is put up for your perusal. In case of approval, we can certainly provide a great support, besides treatment, to the PLHAs in our state.

### **1. Coverage Targets for PLHAs for Nutritional Support**



S. No	District	District Category	Total no. of HIV + persons detected during 2003-2009	Cumulative Number of PLHA alive & on ART (As on 30 Nov 09)	Per head Amount per month
1	Bastar	C	236	46	300
2	Bilaspur	C	619	140	300
3	Dantewada	C	20	16	300
4	Dhamtari	C	64	30	300
5	Durg	A	628	317	300
6	Janjgir-Champa	D	38	25	300
7	Jashpur	C	56	4	300
8	Kanker	D	58	17	300
9	Kawardha	C	86	47	300
10	Korba	C	142	32	300
11	Koriya	D	40	5	300
12	Mahasamund	D	188	58	300
13	Raigarh	C	107	9	300
14	Raipur	C	2979	527	300
15	Rajnandgaon	D	403	107	300
16	Sarguja	D	112	37	300
	<b>State Total</b>		<b>5776</b>	<b>1417</b>	<b>300</b>

**The Total Cost for the Year 2010 – 11 RS. 4.25**

**Note: According to HSS Prevalence, No. of HIV Positive people is estimated to be around 35000 in Chhattisgarh State.**

**As per NACO norms, 10% of Positive people may be in the stage to start ART. This means approximately 3500 persons might be eligible for ART. It is estimated that nearly 2500 persons would be On Art by the end of FY 2010-11**



The mental health program has started in year 1995 With an objective to provide comprehensive care to the people having mental disorder. Concern to the Chhattisgarh state, program is lacking of mental health professionals, leading non functionality of the program. In the coming years state has decided to make more functional and comprehensive program with coordination of different stakeholder under the convergence. In the upcoming years, the main focus will be to build capacity and empowerment of health personnel's in the area of Mental Health. Department of health is already putting efforts to establish centres for excellence guidance of Director of Medical Education, for which team from the central government has already visited to Raipur medical college.

#### **Transit care home :**

Three transit home one each at Raipur, Durg – Bhilai, Bilaspur are proposed from the department of ICDS to provide outpatient care for mentally disable females. Similarly transit care home will also establish Severe mentally disable woman's to provide shelter and therapeutic care. The estimated budget for the medicine as below

#### **Budget Estimate :**

Sl. No.	Budget Head	No. of Unit	Unit Cost	Total (In Lakhs)
1	Transit Care home	12.00 Lakhs	01	12.00

### **B.25 State Health Resources Centre (SHRC)**

State Health Resource Centre (SHRC) is an innovative institutional capacity that was set up in 2002 by state health department of Chhattisgarh, under Sector investment Programme (SIP). Worked as the backbone of the community based health sector reforms in Chhattisgarh, the centre has been able to give shape for a number of successful models of community participation in health like the "Mitani Programme" and "Swasth panchayat." For improving the supply-side interventions on health care, it has developed "Equip approach" through a set of studies and research. In order to improve the facility development and management, it was able to suggest a comprehensive facility development package around the existing Rogi Kalyan Samiti setups, in the form of "Jeevan deep Scheme." Once the SIP was over, the SHRC was absorbed for providing technical assistance in planning and imparting of NRHM. All the community-based components under NRHM are being implemented also, by SHRC, for the state Government. The NRHM has requested other states, to setup similar institutes.

The SHRC have been working as a technical assistance agency to the department. It is supporting on a four-year term under a renewable MOU between the State Health Society



and the SHRC (2008-09 to 2011-12). The technical provided by SHRC support has been as envisaged in the MOU and as approved in the NRHM PIP. This has enabled continuation of SHRC's support function- both for community programmes and for capacity building. Basically, SHRC plays the role of Community hand of NRHM in Chhattisgarh. It is also providing technical assistance to programme and policy design and for support to implementation of innovative, effort and process intensive new programmes. It plays a critical role in capacity building for district health planning. It gives timely inputs to the government wherever it is necessary, in the areas of private sector regulation, insurance, and many other initiatives.

In addition to the areas where SHRC is already working, we have incorporated the SHRC technical support in the field of AYUSH mainstreaming and Medical education this year. In the community level intervention, we are looking at SHRC on operationalising the Village Health & Sanitation Committees. We are supporting the capacity building of officials in district health planning initiatives of the Public Health Resource Network, which have been actively conducting the trainings as planned.

The budgetary needs of SHRC have been envisaged at the same level as previous year.

**Table 3.36: List of outputs achieved by SHRC in 2009-10**

Outputs:
<ul style="list-style-type: none"> <li>Supporting the Mitadin (ASHA) Programme: SHRC provided overall design, capacity building and monitoring support for this flagship community based programme. SHRC designed training materials for 12<sup>th</sup>, 13<sup>th</sup> and 14<sup>th</sup> Rounds of training of Mitadins in consultation with other stakeholders and resource groups. SHRC coordinated on-job and field based support to the Mitadins in terms of providing critical handholding and problem solving support by arranging visits of trained facilitators to locations where Mitadins work. SHR trained, monitored and supported the facilitation cascade of Mitadin Programme through its District Coordinators. SHRC conducted specific micro-studies to observe efficacy of the training inputs being provided to Mitadins. SHRC helped in collection of MIS information on Mitadins' activities from field locations, its analysis and sharing with key stakeholders. SHRC is currently formulating the 15<sup>th</sup> Round of Mitadin Training. It has also facilitated logistics of ensuring that drug kits reach al Mitadins in time. It has also strengthened the Nutrition Security community interventions through the Mitadin programme.</li> <li>Strengthening Village Health and Sanitation Committees (VHSCs): SHRC played a key facilitation role in formation and in account opening of VHSCs across the state. SHRC facilitated the coordination between the health department, Panchayat department and PRIs at the block/grassroots level for establishing VHSCs. For this purpose, SHRC also</li> </ul>



*mobilised the Mitanins and their supporting cascade of Mitanin Trainers, District Resource Persons and District Coordinators to actively facilitate formation of VHSCs, opening of their bank accounts and transfer of untied grant amounts into the bank accounts. SHRC facilitated problem solving wherever gaps existed in understanding of block level officials and PRI representatives. To give a kick-start to this important community based initiative of VHSCs, SHRC coordinated a social mobilisation campaign called 'Gram Swasth Niyojan Abhiyan' across the state and provided trained human resource support to facilitate conduction of special Gram Sabhas on issue of Village Health Planning. Through this process, more than 18,000 VHSCs were initiated and activated. Mitanins being the Convenors of VHSCs in Chhattisgarh, Mitanins and their trainers are playing a critical role in organising meetings of VHSCs and facilitating village health planning in them. So far around 3,000 VHSCs have been able to initiate village health plans and their implementation. SHRC gave a big push to the capacity building for this programme by organising a well designed Training of VHSC members including Panchayat representatives, Anganwadi workers, ANMs, SHGs along with Mitanins. These capacity building efforts have also helped many VHSCs in making good utilisation of the untied grants. SHRC is currently involved in strengthening the capacity of VHSCs further to emerge as the key community institution having PRI participation and active in health planning and its execution.*

- *Formulating Home Based Neonatal Care (HBNC) initiative: In order to give a boost to IMR reduction strategy of Chhattisgarh, HBNC has emerged as an important intervention. SHRC facilitated formulation of a HBNC operational strategy which is based on collaboration between community health workers (Mitanins) and the Primary Healthcare System. SHRC developed the guidelines for the programme implementation, selected blocks in consultation with state NRHM unit, designed training modules by combining the strength of SEARCH HBNC modules with existing neonatal survival programme of Chhattisgarh. SHRC is currently involved in rolling out the ToT and other trainings for this initiative. It is also providing overall support for baseline survey design and execution, coordination and monitoring of programme activities spread across 18 districts of the state.*
- *Strengthening Role of PRIs in Health: SHRC has been at the forefront of conceptualising the 'Swasth Panchayat Yojana' initiative of Chhattisgarh. SHRC has helped in design of panchayat level indicators and Health and Human Development Index (HDI), design of appropriate questionnaires for Swasth Panchayat survey, training of Community volunteers (mainly Mitanins, Panchs and Mitanin Trainers) in data collection, validation of collected data and its compilation, designing a special software for analysis, dissemination of survey findings and facilitating PRIs in making use of the analysed information.*
- *Technical support to AYUSH and Social Mobilisation for AYUSH: SHRC has set up an*



AYUSH cell to act as additional technical capacity to AYUSH directorate and programme unit. It has supported the AYUSHGRAM initiative, designed and executed large scale social mobilisation campaign around AYUSH through AYUSH kalajathas and trained Mitans on AYUSH remedies.

- **Design of Behavioural Change Communication initiatives:** SHRC has designed a full-fledged BCC kit for use of ASHA and Anganwadi Workers. It has also created a consensus on the developed tools through consultation with various agencies. It is currently involved in taking these BCC tools to the grassroots level through training of human resources.
- **HR Recruitment Support to NRHM:** SHRC has helped the state NRHM unit in recruitment of more than a thousand human resources including District and Block Programme managers, data operators etc. It has also extended this support to Malaria Control programme and EUSPP.
- **Operational Research for Policy formulation and Programme Evaluation:** SHRC provided research support to the Health department in critical areas of human resources in health. It has conducted a large study on Health Service Providers in PHCs including Rural Medical Assistants in collaboration with national institutions like PHFI and NHSRC.
- SHRC has conducted a study to assess the ground level situation of Janani Suraksha Yojana.
- **Capacity Building of RMAs:** This important human resource has been recently inducted into the primary healthcare system and requires capacity building support. SHRC is providing support in formulation and execution of training programmes for this specific group of healthcare providers.
- SHRC has initiated preparation of a film on real life heroes in terms of provision of health care in remote areas. It has identified a number of such exceptional doctors who have spent many years providing good quality services in extremely remote rural areas.
- SHRC has started implementation of a training programme for 35,000 Anganwadi Workers across the state on IMNCI in collaboration with the Women & Child Development department.
- SHRC has made significant contribution towards health planning efforts under NRHM. It has facilitated the District Programme Managers in preparation of District Health Plans. It is part of the State Task Force for formulation of the state PIP for NRHM.
- SHRC has been providing technical support for setting up a logistics and drug procurement system for the state including for the creation of a new corporation for the purpose.
- SHRC has provided technical advice in certain policy areas like the Nursing Homes and Medical Establishments Regulation Act (draft), organ transplant policy, non-



communicable diseases policy etc.

- Promoting career pathways of Mitanins: SHRC has provided conceptualisation and handholding support for admission and sponsorship of Mitanin volunteers into BSc (Nursing), ANM and GNM courses.
- Provided technical assistance for planning of European Union State Partnership Programme.

### Focus Areas of SHRC for 2010-11

SHRC will continue its role as additional technical capacity in policy and programme areas of NRHM as well as Department of Health and Family Welfare. In addition to the existing areas of work, the following will be the new initiatives to focus upon in 2010-11

- Operationalisation and handholding support for a 'PIP Cell' at the state level. This cell will track the progress made by various districts in achieving PIP milestones and also help in compilation and appraisal of the Block and District level health plans for the coming year.
- Operations Research in areas like Human Resources in Health, Disease Control Programmes, Non-Communicable diseases, Home Based Neonatal Care Baseline study, Janani Suraksha Yojana, Untied Grant Utilisation pattern at various levels, Jeevan deep (RKS) Samitis etc.
- Technical support for Health Sector Reforms especially in the area of Human Resource policies including reforms in rules and regulations in health services, promotion of public health cadre, medical education.

**Table 3.37: Budget Summary for Technical Assistance to SHRC**

Strengthening SHRC (Under Existing MoU)					
Sl. No.	Unit Description	Unit cost	Unit	Duration	Total
1	Personnel Cost per month	523930	1	12	6287160
2	Studies, Workshops and core publications per event & Travel	229900	1	10	2299000
3	Office Expenditures Equipment and Contingencies	102850	1	12	1234200
<b>Total</b>					<b>9820360</b>
<b>Fund Required from NRHM for year 2010-11</b>					<b>5000000</b>



### **B.25.1**

### **Strengthening Human Resources in Health Sector:**

Inadequate workforce was one of the major hindrances in programme implementation at all levels. Regular appointments were delayed for various posts under NRHM and Directorate of Health Services, Chhattisgarh. So, SHRC was entrusted with the task of Recruitment and Recommendations for Contractual Appointments. Recruitment process was conducted in 2009-10 and recommended lists were sent by SHRC to the concerned Departments for following vacancies :-

#### **Ist Phase**

- **CG State AIDS Control Society: 120 Posts**

Counsellor-55, Lab Technician-53, Divisional Assistant-12

- **NRHM : 216 Posts**

Block Programme Manager-54, Block Accounts and Data Assistant- 52,

Hospital Administrator -15, Computer Programmer-3, Consultant and others-3.

Malaria Technical Supervisor-66, Lab Technician-33

- **Recruitment process conducted and Recommendations sent by SHRC, appointments done for all the above posts**

#### **IInd Phase**

➤ **NRHM : 596 Posts**

- **State Level Posts: 8** (State Advisor- Demography Specialist-1, State Data Officer-1, State Procurement Officer-1, State Human Resource Officer-1, State Data Assistant-Immunization-1, Accountant-3)

- **District Level Posts: 124** (District Programme Manager-2, District Accounts Manager-6, District Data Officer-4, Accounts Assistant-94, District Data Assistant-18)

- **Block Level Posts: 464** (Block Programme Manager-92, Accounts and Data Assistant-350, Data Entry Operator-22)

➤ **NVBDCP: 27 Posts** ( GIS Data Entry Operator-1, Accountant-1, Secretarial Assistant-1, Insect Collector-2, Financial and Logistic Assistant-11, Data Entry Operator-11)

➤ **Leprosy Control Programme: 6 Posts** (Data Entry Operator-6)

➤ **Recruitment process conducted and Recommendations sent by SHRC for the above posts**



➤ **European Union State Partnership Programme: 9 Posts (In process)**

Still many approved positions under NRHM and Directorate of Health Services are lying vacant which are to be filled on a priority basis. For the backlog as well as fresh vacancies of 2010-11, a tentative budget of Rs. 5 Lakh is to be allotted specifically for conducting the Recruitment process to meet the workforce requirements and keep the demand-supply gap to the minimum possible.

**Estimated budget:**

S. No.	Description	No. of Unit	Unit cost	Total
1.	Budget for Recruitment process.	--	500000	500000
<b>Total</b>				<b>500000</b>

**B27 NRHM Management Costs/ Contingencies**

**Strengthening of Programme Management Support Unit**

Strengthening of state, district & block level PMUs as per GOI guideline; will strengthen and ensure proper fund & data management across all levels of health institutions through computerised data flow. To strengthen and facilitate various functions of SPMU, six new consultant positions are created along with twenty supporting staff. At District and block levels, one data entry operator is proposed to help in smooth functioning of program units. Additional HR at the PHC level for 316 accounts and data assistants which were not sanctioned in financial year 2009-10 are proposed this year. The budget for mobility support, office expenses & contingencies of all Program Units are proposed for further strengthening of the PMUs.

**Table: Strengthening State PMU & NRHM Secretariat**

S. no.	Unit Description	Unit cost	No. of Units	Duration in months	Total Cost
1	State Cold Chain Engineer	30000	1	9	270000



2	State Reporting & Documentation Consultant	25000	1	9	225000
3	State Administrative Assistant (Event Organizer)	18000	1	9	162000
4	State Administrative Assistant (Office)	18000	1	9	162000
5	State Graphic Designer	18000	1	9	162000
6	System Consultant (Hardware)	15000	1	9	135000
7	Stenographer (1 English & 1 Hindi)	15000	2	9	270000
8	Computer Programmer	24000	4	6	576000
9	Peon/ Chowkidar /Sweeper	4500	5	9	202500
10	Data Entry Operator	7000	19	12	1596000
11	State level Travel /mobility of PMU officials ( inclusive of 4 vehicles for SPMU pool & 2 Vehicles for programme activities AND mobility support for district visit @ 5days X 10 official every month)	230000	1	12	2760000
12	DA and accommodation during District visits	1500	50	12	900000
13	Office Establishment/ Contingencies	635000	1	12	7620000
<b>Total</b>					<b>150.40 lakh</b>

**Table: Strengthening District PMU**

S no	Unit Description	Unit cost	No. of Units	Duration in months	Total Cost
1	Data Entry Operator	7000	70	12	58.80 lakh
2	District Level Mobility of PMU officials	11500	18	12	64.80 lakh
3	District level PMU Coordination &	18400	18	12	39.74 lakh



	Contingencies				
<b>Total</b>					<b>163.34 lakh</b>

**Table: Strengthening Block PMU**

S no	Unit Description	Unit cost	No. of Units	Duration in months	Total Cost (lakh)
1	Data Entry Operator	7000	146	12	122.64
2	Account and data assistant (PHC level)	6000	366	12	263.52
3	Block Level Mobility of PMU officials	11500	18	12	24.84
4	Block level PMU Coordination & Contingencies	18400	18	12	39.74
<b>Total</b>					<b>450.74</b>

#### **Bal Hruday Raksha Yojana: Chief Ministers' Child Heart Protection Scheme**

The objective of the scheme is to provide health care to the children of poor and needy families between the age of 1 to 15 years who are suffering from heart diseases and require surgical treatment in Chhattisgarh. Such heart surgeries will be carried out for free of cost in selected hospitals of Chhattisgarh under the Chhattisgarh Health Committees, National Rural Health Mission. In addition to the expenses of heart surgery, additional expenses of the family members will be borne by the state.

To achieve the given objective the representative of State Health Committees, the Director of Health & Family Welfare, Chhattisgarh will be liable to pay the decided amount for the services rendered by the Hospital in cash, cheque or bank draft upon production of certificate for each surgery.

#### **Status of Bal Hruday Suraksha Yojana**

With a great success of the scheme, last year of 2009-10 total 1146 application were received out of which 1140 application were referred to respective hospitals. The details are mentioned in the below table.



S. No.	Name of hospital	No. of case referred	No. of case operated	Total amount (lakh)
1	Apollo BSR Hospital, Bhilai	464	237	208.68
2	Escort Heart Centre, Raipur	296	235	164.39
3	Ram Krishna Care Hospital, Raipur	352	176	89.18
4	Apollo Hospital, Bilaspur	241	136	72.81
5	Case referred to out of state.	36	36	58.49

**Table: Financial status of Baal Hruday Suraksha Yojana**

S. No	Fund Received from NRHM in 2009-10	Fund from other source (EUSPP)	Total fund	Total expenditure	Opening balance	Budget requirement for year 2010-11 (lakh)
1	30000000	38200000	68200000	58779978	9420022	1379.60

**Out of 1379 lakh only 500 lakh will be provided from NRHM Budget.**

**Table: Budget Summary for Baal Hruday Suraksha Yojana for 2010-11**

S. No	Item	No. of Unit	Unit Cost	Durati on	Total cost (lakh)	Grand Total (lakh)
	<b>Expenses on surgery</b>					
	General Surgery	800	130000	1	1040.00	
	Critical Surgery	125	150000	1	187.50	
	Single Valve Replacement Surgery	75	180000	1	135.00	1362.50
	<b>Administrative Cost</b>					
	State Co-coordinator	1	45000	12	5.40	
	Technical Consultant	1	35000	12	4.20	
	Accountant	1	15000	12	1.80	
	Office Assistant (Computer Operator)	2	10000	12	2.40	13.80



<b>Non recurring expenditures</b>						
Furniture & fixture, Computer etc.	1	50000	1	0.50		
Office Expenses	1	15000	12	1.80		
Contingency Expenses ( IEC)	1	100000	1	1.00		3.30
<b>Grand Total</b>						<b>1379.60</b>

### **Cochlear Implant for Children with Hearing Difficulty**

Communication is the most important requirement for survival of human civilization. Speech and language are important tools for communication, which develop in early years of life for which intact hearing is required. While in adults and in post lingual deafness hearing is essential for preservation of speech.

Cochlear Implant is an electronic device useful in profound hearing impairment. When hearing aid of even strongest variety fails then cochlear implant may help in restoring the hearing loss.

Cochlear implant is very useful in congenital hearing loss. In adults, it may be useful in hearing loss caused by diseases, Ototoxic drugs, and trauma or due to senility. Cost of the implant varies from 5 to 10 lakh.

Most of the democratic governments in west have accepted that it is the responsibility of government to provide all necessary assistance to its disabled citizens. India as a democratic country is also responsible for providing all sorts of help to its handicapped citizens.

### **Burden of the Problem**

According to Census 2001, the total number of disabled in India was 21 million – more than 2% of total population. Out of this, 75% resides in rural area. However, according to “National Sample Survey Organization (NSSO, 58th round, 2002), “estimated number of disabled persons in the country is 18.49 million, about 1.8% of the total population. Out of all disabled persons, residing in India 29% comprises of hearing and speech disabilities. Approximately, 3061700 are hearing disabled and 2154500 are speech disabled.

The population of Chhattisgarh state is around 2.1 crores and thus approximate figures for hearing disabled and speech disabled will be around 60,000 and 43,000 respectively. About one third (20,000) of these can be considered as congenital deaf and approximately 40 % (8,000) of these require cochlear implant. The rest i.e. around 50% (10,000) can be managed



by proper hearing aid; remaining 10% require special education and training in special schools.

### Management Strategies

The management of deafness (Sensory Neural) has to be done by proper hearing aid. In case hearing aid is unable to cope with the handicapped, cochlear implant remains the only answer for preservation of speech in post lingual and development of speech in congenital deafness.

A small percentage of children cannot be helped even by cochlear implant and in these cases education & training in special School is essential. The Cochlear implant surgery being very expensive owing to the cost of implant, which is imported, is not being utilized as often as necessary. Another reason for underutilization of this facility is the prolonged post implant speech therapy in a proper centre. Because of these two factors, the patient has to be prepared to undergo surgery, which is available at limited number of centres in India and prepared to stay there for post-implant therapy programme, which may require 3 to 4 years. Thus, it becomes unfeasible for most of the parents of middle or lower economic status to take the benefit of this technique for their children. Realizing this fact department of ENT Medical College, Raipur has developed facilities for investigations required to assess the candidacy, cochlear implant surgery as well as for post implant speech therapy. Until now, six cochlear implant surgeries have been done and the children are undergoing post implant speech therapy at the speech therapy centre of the department.

### Strategies:-

1. Child having age less them 3 years.
2. Examination and screening of children.
3. Screening for congenital disease
4. Pre operation cancelling.

### Financial Implications

As per one American study the cost of each method is as follows, (this can be assessed in Indian context also).

S.N.	Methods	America	India
1	Hearing Aid	400-500 \$	Rs. 10000-15000
2	Cochlear implant	5000-6000 \$	Rs. 6 - 7 lakh
3	Training in special schools and other supports.	40,000 \$	Rs. 12- 13 lakh



*In view of the high cost of cochlear implant, it is desirable that all deserving candidates get suitable assistance in procuring it. This assistance can be provided by government, international organization working for the disabled person, public sector units, big industrial houses and other philanthropic organizations. Thus, attempts should be made to arrange finance from all possible sources.*

*Since the facility for cochlear implant surgery and the post implant therapy is available at this centre, here the main expenses would be only in procuring the cochlear implant.*

*In view of large number of children requiring cochlear implant, a massive grant is essential so that the facilities for the surgery and post implant therapy can be developed at few more centres. However, until then a grant from any source will help in continuing the cochlear implant surgery at this centre.*

*At the rate of two such surgeries per week the approximate number would be 100 per year and thus a grant of 5-6 crores will be required, for this year scheme may be started at least proposed amount 2 crore rupees.*

### **Expected Outcome**

*The rate of successful outcome after cochlear implant is more than 95% in suitably selected candidates. Thus, one time expenditure of 5-6 lakh for a child can change his entire life, make him equally useful member of the society and it is likely that many of these children can return much more to the society in their lifetime.*

### **Budgetary Requirement**

*The overall cost for implementing this programme will be Rs. 1 Crore.*

#### **Telephone connection in Sub Health Centre/ PHS/CHC and District hospital**

*As per the approved PIP2007-08 there was sanction of Rs. 1 crore for 5500 tele-phone connections in all levels of health institutions , as on now 5200 tele-phone connections has been established. As per the MOU with BSNL 45lakh has been paid to BSNL, rest of the amount **Rs. 55 lakh** will be paid to BSNL as soon as the work order accomplished.*

#### **Mobile medical Unit.**

*In the state of Chhattisgarh where the population density is quite 154 per sq km. and the habitation is quite disperse dispensing heath services is a challenge. In order to provide basic*



health facility to these under served and unserved area the state need to take help of mobile health clinics. In the year 06-07 Gol has given funds to procure such vehicle which will house one examination area , one lab testing area, one drugs dispensing area and one staff vehicle. State is in process of procuring such vehicle. These vehicles will have two doctors (contractual) staff nurse, lab technician and one pharmacist as medical unit and in non medical unit one supervisor and two drivers. This unit will be made operational by mostly by contractual staff and Local NGOs who will help to organize family planning camps for male, Minor operation, malaria checkups, follow-ups, etc. For operational purpose each vehicle will be issued untied fund of Rs 5 lakhs each in every quarter and will be asked to organize three camps per week.

The budget proposed for this project already been sanctioned in the previous year 2007-08 PIP and one prototype MMU has been reached to state and other MMU are under manufacturing, so the unspent balance of **Rs. 782.72** will be used during this financial year 2010-2011.

### **Integrated outreach camps in difficult areas.**

Bijapur and Dantewada are the two most difficult areas in terms of geographical areas as well as naxal affected situations, Bijapur and Dantewada have the 95% of tribal population with low socio economic conditions. Due to the lack of health professional and difficult situations it is challenge for the department to cater health services to the people of this areas. So after discussions with developmental partners and the officials of department it is decided to establish integrated health outreach camps in collaboration with Red Cross Society.

## **2. Objective of this programme.**

### **2.1. Overall General Objective**

The overall objective is to respond to health needs in some violence affected areas of Chhattisgarh State, by improving First Aid services, referral systems for emergencies, outreach health services and surgical management of injured persons.

### **2.2. Specific objectives for 2010-11**

#### **First aid posts.**

Injured persons in the two violence-affected districts of Bijapur and Dantewada benefit from First Aid services provided by 20 trained and equipped Red cross volunteers in 10 selected villages.



### Improvement of the ambulance referral system

Part of the population from the Bijapur and Dantewada districts benefits from free of charge services from 2 ambulances managed by the department and Red Cross.

### Training in first aid / dissemination

At least 20 ambulance drivers, 25 community health workers (Mitanins) and 50 NRHM / departmental personnel posted in Sub Centres and Primary Health Centres in Bijapur and Dantewada districts are able to provide proper first aid and stabilise wounded patients before referring them.

Selected members of the State Police personnel benefit from a First Aid training of trainers' module so that they could conduct First Aid training for the Police forces.

### Mobile clinics in Chhattisgarh State

Part of the population of Bijapur and Dantewada districts benefits from the health services provided by one mobile clinic posted in each district. The two mobile clinics implement outreach activities corresponding to the State Public Health Strategies, with emphasis on vaccination, malaria control measures and health promotion / disease prevention.

### Surgery seminar in Chhattisgarh State

25 surgeons of Chhattisgarh State benefit from an Red Cross surgery workshop in order to improve the management of victims of violence.

### 3. Human resources / Planning / monitoring

Red cross health delegate supported by an Indian medical assistant will be posted in Chhattisgarh State by the end of February, with the involvement of the Red Cross will ensure the coordination of the health programme, including planning, monitoring and ongoing evaluation / review of the activities. A reporting system, as well as regular coordination meetings with the different stakeholders, will be put in place. Activity reports will be shared with the department of health and family welfare.

### 5. Role and responsibility for the implementation

Activities	Role & responsibility from ICRC / RED CROSS	Role & responsibility from NRHM
RED CROSS First Aid posts	<ul style="list-style-type: none"> <li>Designation of RED CROSS volunteers.</li> <li>Training in First Aid (FA)</li> <li>Rehabilitation of FA posts</li> <li>FA post equipment</li> <li>Supply of renewable material</li> <li>Monitoring of activities</li> </ul>	<ul style="list-style-type: none"> <li>Participation in the selection of the locations.</li> </ul>



<b>Ambulances</b>	<ul style="list-style-type: none"> <li>▪ Recruitment and salary of drivers (+ accommodation in the field)</li> <li>▪ Management of drivers and ambulances.</li> <li>▪ Means of communication (mobile phones)</li> <li>▪ Monitoring of activities</li> <li>▪ Reporting to authorities (activities and financial)</li> </ul>	<ul style="list-style-type: none"> <li>▪ Participation in the selection of the locations.</li> <li>▪ Donation of equipped ambulances.</li> <li>▪ Coverage of running costs (i.e. fuel, maintenance, insurance, supply of equipment &amp; renewable items)</li> </ul>
<b>FA courses</b>	<ul style="list-style-type: none"> <li>▪ Trainers.</li> <li>▪ Organisation of the different modules and payment of the incurred costs (transport, stationary, food, training material)</li> <li>▪ Reporting of activities to authorities</li> </ul>	<ul style="list-style-type: none"> <li>▪ Participation in the selection of trainees.</li> </ul>
<b>Mobile Clinics</b>	<ul style="list-style-type: none"> <li>▪ Recruitment and salary of staff (+ accommodation in the field)</li> <li>▪ Management of the Mobile Clinics</li> <li>▪ Means of communication (mobile phones)</li> <li>▪ Part of mosquito nets</li> <li>▪ Monitoring of activities and development of Health information system.</li> <li>▪ Reporting to authorities (activities and financial)</li> </ul>	<ul style="list-style-type: none"> <li>▪ Participation in the selection of the locations</li> <li>▪ Donation of equipped mobile clinic vehicles.</li> <li>▪ Coverage of running costs (i.e. vehicles insurance, fuel &amp; maintenance)</li> <li>▪ Supply of medicines, vaccines &amp; cold chain, malaria diagnostic tests, part of the mosquito nets, etc.</li> </ul>
<b>Surgery seminar</b>	<ul style="list-style-type: none"> <li>▪ Food &amp; Accommodation</li> <li>▪ Transport of participants</li> <li>▪ Surgery books and handouts</li> <li>▪ Salary &amp; mission expenses of two surgeons' trainers from ICRC headquarter.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Participation in the selection of participants.</li> </ul>

### **5. Budget summary**

The following table provides only estimation of the programme direct costs. It excludes the costs linked with the technical support provided by the ICRC/RED CROSS such as human resources or administrative setup needed for the programme.

<b>Activities</b>	<b>Estimated Cost</b>	<b>Contribution ICRC</b>	<b>Proposed contribution</b>
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	(Indian Rupees) in Lacs			NRHM	
		INR	%	INR	%
RED CROSS 1st Aid posts	3.66	3.66	100%	0.00	0%
Ambulances Running cost	17.82	2.82	16%	15.00	84%
FA courses	4.76	4.76	100%	0.00	0%
Mobile Clinics	66.43	27.80	42%	38.62	58%
Surgery seminar	2.86	2.86	100%	0.00	0%
<b>TOTAL</b>	<b>95.54</b>	<b>41.91</b>	<b>44%</b>	<b>53.62</b>	<b>56%</b>

#### Plan for Left Wing Extremists' affected area

There are seven districts which are facing left wing extremities in the state. Out of seven, five of them are in the Bastar region. These five districts are one of the most remote districts of India. In general these districts are lacking in the basic amenities including transportation & communication facilities, electricity, water supply, skilled human resource as compared to other districts of the empowered Chhattisgarh state. The access to The combination these classical features along with the left wing extremities had been responsible along really ones which are having extremely poor The total budget required per the LWE budget submitted by the districts.



Sl. No.	District	Amount proposed from District	Building (Staff Qtr., Transit Hostel),	MMU	Vehicle	Camps	Solar Light	Staff Appointment	Activities	Machinery	medicine	other	Total Amount
1	Bastar	180.00	180.00										180.00
2	Narayanpur	444.25	308.00	31.50	48.00	10.00	8.50	16.90	21.35				444.25
3	Dantewada	1699.74	1255.00	117.30		54.00	114.60	61.32	85.10	12.36			1699.68
4	Bijapur	2852.57	2521.00	16.00	30.15	87.00	29.50	166.92		2.00			2852.57
5	Kanker	3346.80	1380.40		124.40					1600.00	232.00	10.00	3346.80
6	Sarguja	120.00	120.00										120.00
7	Rajnandgaon	6407.50	6407.80										6407.80
	<b>Total</b>	<b>15050.86</b>	<b>12172.20</b>	<b>164.80</b>	<b>202.55</b>	<b>151.00</b>	<b>152.60</b>	<b>245.14</b>	<b>106.45</b>	<b>1614.36</b>	<b>232.00</b>	<b>10.00</b>	<b>15051.10</b>



## C IMMUNISATION

### C. IMMUNISATION

*The number of districts in Chhattisgarh has increased from 16 to 18 since last year and District Immunization Officers are also posted in these districts. The plan is accordingly prepared to include these two additional districts.*

*There are 21000 sessions organized every month in the State, out of which 1000 are in urban areas. In urban areas, special micro planning will be done to include all the slums and habitations and link them up with immunization session sites. These sessions sites in urban areas will be in every AWC and in neighbouring private clinics. The hiring charges of ANM in urban area will be paid to vaccinators of private clinics if immunization session is conducted in their premises. The alternate vaccine delivery in urban areas will be outsourced to private courier companies. Also in urban areas, the AWW and AW Sahiyika will receive Rs. 100 and Rs. 50 per month respectively as incentive for mobilization of beneficiaries. In rural areas, Chhattisgarh has 60000 mitanins (ASHA) who mobilize children and each will receive Rs. 50 per month for mobilizing beneficiaries.*

*Also as the State lacks adequate staff to manage cold chain and vaccine management at State and District level, personnel will be staffed at these levels. At the district level, a trained pharmacist / MPW will be drawn up from the health system and paid an extra incentive of Rs. 5000 for managing the cold chain / vaccine management. At the same time, at the State level, a fresh contractual recruitment will be made of a pharmacist with the knowledge of computer operation.*

*It is also planned to incentivize health workers and other staff if their working area achieves more than 90 percent immunization coverage. This is also planned and budgeted for 2010 – 2011.*

*At the same time, WIC installation at the State level will be done through the support of UNICEF.*



Budgetary Requirement					
Service Delivery: -	Norms*	* Description	2010 - 11		Remarks
			Funds requirement	Target	
<b>Trainings</b>				No of persons trained	Funds will be sourced from budget that is already available from NRHM PIP 2009 - 10
District level orientation training for 2 days ANM, Multi Purpose Health Worker (Male), LHV, Health Assistant (Male / Female), Nurse Mid Wives, BEEs & other specialist ( as per RCH norms)	As per revised RCH norms for trainings, copy attached				
	Resource Person				
	Venue Hiring Charges				
Three day training of Medical Officers on RI using revised MO training module	As per revised RCH norms, copy attached			No of persons trained	Funds will be sourced from budget that is already available from NRHM PIP 2009 - 10



Budgetary Requirement						
Service Delivery: -	Norms*	* Description	2010 - 11			Remarks
			Funds requirement	Target		
	Resource Person					
	Venue Hiring Charges					
One day refresher training of District RI Computer Assistants on RIMS/HMIS and Immunization formats under NRHM	As per revised RCH norms , copy attached	=Rs 1000* 19	19000			
	Resource Person	= 1 batch * 1 day* Rs1000/-	1000			
	Venue Hiring Charges	=1batch* 1day* Rs 10000/-	10000			
One day Cold Chain handlers training for block level cold chain handlers by State and District Cold	As per revised RCH norms, copy attached	=Rs 450/* (146 Block)	65700	No of persons trained		



**Budgetary Requirement**

Service Delivery: -	Norms*	* Description	2010 - 11			Remarks
			Funds requirement	Target		
Chain Officers and DIO for a batch of 15-20 trainees and three trainers						
	Resource Person	= 8 batch * 1 day* Rs 1000/-	8000			
	Venue Hiring Charges	=8batch* 1day* Rs 8000/-	64000			
One day Training of block level data handlers by DIO and District Cold chain Officer to train about the reporting formats of Immunization and NRHM	As per revised RCH norms, copy attached	Rs 450/- * 146 blocks	65700	No of persons trained		
	Resource Person	= 8 batch * 1 day* Rs 1000/-	8000			



<b>Budgetary Requirement</b>					
<b>Service Delivery: -</b>	<b>Norms*</b>	<b>* Description</b>	<b>2010 - 11</b>		<b>Remarks</b>
			<b>Funds requirement</b>	<b>Target</b>	
	Venue Hiring Charges	=8batch* 1day* Rs 10000/-	80000		
<b>Micro planning</b>					
To develop sub-centre and PHC micro plans using bottom up planning with participation of ANM, ASHA, AWW	@ Rs 100/- per sub centre (meeting at block level, logistic)	4716* Rs100/-	471600	100% of SC/PHC/CHC/Districts	
	For consolidation of micro plan at PHC/CHC level @ Rs 1000/- block & at district level @ Rs 2000/- per district	(146* 1000) + (16*2000)	178000	have updated micro plans every year	
<b>POL for vaccine delivery from State to District and from district to PHC/CHCs</b>	Rs100,000/ district/year and Rs. 200,000 / - at state level	18 district*100000 + 20000 at State level	2000000	% Funds used	
<b>Consumables for computer including provision for internet access for RIMS / HMIS</b>	@ 400/ - month/ district	(Rs 400/- * 12* 18 districts) + (Rs 400/- * 12 * 1 state level)	91200		
<b>Injection Safety</b>				% Funds used	



<b>Budgetary Requirement</b>					
<b>Service Delivery: -</b>	<b>Norms*</b>	<b>* Description</b>	<b>2010 - 11</b>		<b>Remarks</b>
			<b>Funds requirement</b>	<b>Target</b>	
Red/Black Plastic bags etc	@ Rs 2/bags/session	Rs 2/- * 2 bags per session * 21000 sessions * 12 months	1008000		
Bleach/Hypochlorite solution	@ Rs 500 per PHC/CHC per year	Rs 500 /- * (716 + 146)	431000		
Twin bucket	@ Rs 400 per PHC/CHC per year	=Rs 400/- * (716+146)	344800		
<b>Any State Specific Need with justification</b>					
Temperature record books	Rs. 40 per cold chain equipment per year	Rs. 40 * 1500	60000	% Funds used	
Chart on injection safety	Rs. 12 * (723 CHCs + 136 PHCs + 4692 SCs)	Rs. 12 * 5551	66612		
Strengthening of District Cold chain room	Rs. 500,000 per district	Rs.500000 *18	9000000		
Strengthening of Block cold chain room	As per district plans. Total 28 block level cold chain room @ Rs. 50,000	Rs. 50000 * 28	1400000		



Budgetary Requirement					
Service Delivery: -	Norms*	* Description	2010 - 11		Remarks
			Funds requirement	Target	
Extra incentive to District level cold chain and vaccine manager		Rs. 5000 *18*12	1080000		
Hiring of pharmacist for cold chain and vaccine management at State level		Rs. 15000*12 Training Rs. 20*5000	360000 100000		
best 2500 village 8 person per@200/-	Rs. 2500 *8*500	Rs. 2500 *8*200	4000000		
Five best sub centres per district receiving prize money of Rs. 1100 for more than 90 percent coverage of fully immunised children below one year of age		Rs. 1100 *5*18	99000		



Budgetary Requirement					
Service Delivery: -	Norms*	* Description	2010 - 11		Remarks
			Funds requirement	Target	
Three best PHCs per district receiving prize money of Rs. 2100 for more than 90 percent coverage of fully immunised children below one year of age		Rs. 2100*3*18	113400		
One best block of each district receiving prize money of Rs. 51000 for more than 90 percent coverage of fully immunised children below one year of age		Rs.51000*18	918000		
Three best districts will receive an award citation worth Rs. 21000		Rs. 21000*3	63000		



Budgetary Requirement					
Service Delivery: -	Norms*	* Description	2010 - 11		Remarks
			Funds requirement	Target	
Verification of claims for best performance		Rs. 400000	400000		
WIC installation at Janjgir Champa and Sarguja districts	Rs. 500000 per site	Rs. 500000*2	1000000		
Solar Electrification on Salva Judum camp	Rs. 200000 per camp	Rs. 200000*25	5000000		
<b>Total</b>			<b>973.70</b>		



## D NIDD

### D. National Iodine Deficiency Disorders Control Programme (NIID)

#### Situation Analysis

In the 1960s, correction of iodine deficiency was exclusively handled through administration of iodine in the form of potassium iodide solution or Lugol's solution. Initially, IDD was thought to be a problem in the sub-Himalayan region. **The highly endemic region of India is the sub-Himalayan belt stretching from Kashmir in the Northwest to the Naga Hills (Nagaland) in the East, extending about 2,400 km.** However, surveys carried out subsequently by the Ministry of Health and Family Welfare (MOHFW) showed that iodine deficiency disorders exist even in riverside and coastal areas. Goitre surveys conducted in 283 districts in 25 States and four Union Territories over a wide period of time (1960's to 1990's) have identified 241 districts as IDD endemic. **No state / UT in India is free from IDD.** The implications of iodine deficiency for the unborn are of serious concern in India where 25 million women become pregnant each year. Half of the newborn is unprotected against brain damage simply because their mother did not consume adequately iodized salt during their pregnancy. Impact of iodine deficiency on physical performance and productivity of adults cannot be underestimated in a country where the population below poverty line, nearly a third of the total population, depends on physical labour for its livelihood.

In the state of Chhattisgarh, salt from 59 percent of households were found with > 15 PPM iodine, another 9 percent were found to have 1 to 15 PPM of Iodine, while salt from 30 percent households did not have iodine (**Coverage Evaluation Survey, UNICEF & GOI 2005, Iodine**).

#### Activities:

1. Set up an IDD control cell comprising of representation from DOHFW, DWCD, Education department, Civil Supplies and Salt Traders, civil society organizations like UNICEF who meet regularly to monitor & evaluate progress towards achieving USI.
2. Regular rapid testing of salt quality in all government programs (like ICDS-supplementary nutrition program, MDM) through use of MBI Salt Testing Kits.
3. Regular reporting on the quality of the tested salt that is collated at block/district and state level. This report is used to initiate action by authorities at various levels.
4. Initiate road and railway check points to prevent entry of non-iodized salt into the state.



5. *Initiate the school movement for iodized salt program- a program guided towards increasing awareness on iodize not only within the students but also among their families and neighbours.*
6. *Regular meetings with the salt traders and promote sale of iodized salt.*
7. *Conduct IDD surveys in all the 18 districts*
8. *Supporting Sishu Sanrakshaan Maah for use of iodized salt.*
9. *Awareness campaign and celebrating world iodine day: As awareness generation, campaign worldwide celebration of 'world iodine day' on 21 October every year. This year state will decide to celebrate this day as awareness generation programme.*

### **Monitoring of Programme**

1. *State level technical committee will be set up for monitoring the programme in which, Join Director of the programme, representative from technical supporting organisation like State Health Resource Centre, UNICEF, CARE and Micronutrition Initiative will be the part of the committee. Bi annual evaluation will be done with a representative sample from the entire districts as well as evaluation of each district programme.*
2. *A District level team will be formed for operationalising evaluation and monitoring of programme based on indicators like percent of household using IODIZED Salt and Use of IODIZED salt in Government run programme.*

### **Budget:**

S. No.	Description	Amount proposed (lakh)
1.	Establishment of IDD Control Cell	4.50
2.	Establishment of IDD monitoring Lab	00
3.	Health Education and Publicity	3.00
4.	IDD Survey	1.50
5.	Cord Blood Test	6.50
	<b>Total</b>	<b>15.5</b>

*For NIDDCP, budget should be obtained through State Health Society because through treasury rout state finds difficulty to mobilise the fund.*



# E - Integrated Disease Surveillance Project

## E. Integrated Disease Surveillance Project

### Situation Analysis

Integrated Disease Surveillance Programme has been envisaged to be the backbone of the public health programmes in India. IDSP will provide the essential data to monitor the progress of on-going disease control programmes and help in allocation of resources and will be crucial in obtaining political and public support for the health programmes. It will help to identify areas of health priority where more inputs are necessary. The programme will capture data on both communicable and non-communicable diseases, to capture the epidemiological transition through which India is passing, through different surveillance mechanisms.

It is against this background that the programme has been launched in Chhattisgarh in the year 2005.

### Core conditions under surveillance in IDSP:

Currently, the following diseases are being monitored through IDSP

<b>Regular surveillance:</b>	
Vector borne disease:	Malaria
Water borne disease:	Acute diarrhoeal diseases (Cholera)
	Typhoid
Respiratory diseases:	Tuberculosis
Vaccine preventable disease:	Measles
Diseases under eradication:	Polio
Other international commitments:	Plague
Unusual syndrome:	Meningo-encephalitis, respiratory distress, Haemorrhagic fevers,



	others
<i>Sentinel surveillance:</i>	
<i>Sexually transmitted diseases/ Blood borne other conditions</i>	<i>HIV/HBV, HCV</i>
<i>Regular periodic surveys:</i>	
<i>NCD risk factors</i>	<i>Anthropometry, Physical activity, blood pressure, tobacco, Nutrition etc</i>
<i>Chhattisgarh-specific diseases</i>	
<i>1. Leprosy 2. Viral Hepatitis 3. Neonatal Tetanus 4. Diphtheria</i>	

Over the years considerable progress has been made through IDSP which are summarised as following:

#### **Structure of IDSP in Chhattisgarh**

- SSU – 1
- DSU – 16  
(Establishment of 2 more DSUs are under process)
- No. RUs For “S” SURVEILLANCE – 4741
- No. Of RUs For “P” SURVEILLANCE – 865
- No. Of RUs For “L” SURVEILLANCE – 191
- No. Of RUs for “E. W. S.” – 16 / 18
- No. Of RUs For Outbreak Information – 16 / 18
- No. Of RUs For Dengue / Chikunguniya – 16 / 18

#### **Staff Position in IDSP:**

With the appointment of 13 district epidemiologist, 1 state epidemiologist, 1 entomologist and 1 microbiologist the human resource of the IDSP unit has gained considerable strength. However, attrition of health workers continues to be a challenge.



Table: Staff Position under IDSP

S. No.	Designation	Sanctioned post	Working	Vacant
1	SSO	1	1	0
2	DSOs	18	16	2
3	State Epidemiologist	1	1	0
4	State Microbiologist	1	1	0
5	State Entomologist	1	0	1
6	State Data Manager	1	1	0
7	State Training Consultant	1	1	0
8	State Finance Consultant	1	1	0
9	Administrative Assistant	1	1	0
10	State Data Entry Operator	2	0	2
11	Helper	1	0	1
12	District Epidemiologist	18	13	5
13	District Microbiologist	1	0	1
14	District Data Manager	18	15	3
15	District Data Entry Operator	18	12	6
16	District Accountant	18	10	8
17	District Administrative Assistant	18	8	10
18	Medical College Data Entry Operator	3	1	2



*\*DSU's at District Narayanpur & Bijapur are yet to be Established. All posts in the two new districts except district Epidemiologist at Bijapur are vacant. Recruitment subjective to sanction of DSU's in the two districts by CSU.*

### **IT component under IDSP:**

The IDSP unit, supposed to function in real time in collaboration with NCDC, NIC and CSU as well as submit online data entry, has a large number of IT related gadgets. The current position is as following:

- EDUSAT unit at SSU – established and functioning.
- EDUSAT unit at 3 Medical Colleges – established but not functioning.
- V-SAT units at 16 DSUs – installed but not functioning
- Telephone & broadband connections have been provided at SSU and 16 DSU.
- Online data entry - from SSU & all DSUs.
- Video conferencing between CSU & SSU on all Fridays from 3.30pm to 4.30 pm. However, at present there is only one-way connection from CSU to SSU although it was envisaged to be two-connections between CSU & SSU and SSU & DSU.

### **Training:**

During the last year a large number of health staff has been trained under this programme in several fields. The following table shows the details of the training.

**Table: Training status under IDSP**

S. No.	Name of training	PIP target	Actual target	Achievement	Balance
1	Field epidemiology training for DSOs	0	18	8	10
2	Training of BMOs at state level	114	146	134	12
3	Medical officers' training	532	1337	581	756
4	Lab technicians' at state level	32	40	27	13
5	Training of lab assistant	114	146	103	43
6	Training of MPW	3637	7274	5653	1621
7	State / district surveillance team / RRT	69	69	64	5



8	Data managers	16	18	14	4
9	District accountants	16	18	12	6
10	Data entry operators	16	21	13	8
11	State / District epidemiologist	0	19	14	5
12	State / District microbiologist	0	2	1	1
	Total	4546	9108	6658	2450

### **Online reporting of Outbreaks:**

Online reporting of outbreaks has been envisaged as a key component under the IDSP. During last year several outbreaks reported in different parts of the state have been posted in the IDSP portal along with the action undertaken and current situation. This is helpful in ascertaining the control measures undertaken. It helps the higher officials to ascertain the geographic distribution of the outbreaks.



## Disease Outbreak Reported for Decision Makers for All Districts of State Chhattisgarh

Reporting Period For Year:2008, between 29-12-2008 and 20-12-2009

S. No.	District	Disease/ Syndrome	Area Affected (Block, PHC, HSC, Village)	No of Cases	No of Deaths	Date of Outbreak	Date of Reporting	Population of Affected Area	Salient epidemiological observations	Lab results	Control measures undertaken / Any other Information
1	BILASPU R	Dengue Like illness	Green City, Usalapur (Block Takhatpur), and Municipal Corporation Area (SECL, Railway Colony, Sakanda, Vyapar Vihar, Surya Vihar, Sirgitti etc.), total 10 cases 2 deaths. In addition cases were admitted from other districts as well. Korba 24 cases, 4 deaths, Koriya District 9 cases, 3 deaths, Janjgir- Champa	57	11	15/0 9/20 09	09/1 0/20 09	40000	The 1st Case was detected on 29 June 2009 at Apollo Hospital, Bilaspur.	95 Sample tested and 54 cases found positive for IgM test	All these information gathered from Apollo hospital and private nursing homes Bilaspur.



2	KAWAR DHA	Diarrhoe a	Block-Pandariya, PHC-Chhirpani, Sub- senter-Chiyadad, Village-Mangali	18	1	03/0 7/20 09	09/0 7/20 09	960	Diarrhoe a	Rectum swab & water sample for Testing to the Medical College Raipur	1. Organized Health Camps, 2. Serious Cases (4) referred to CHC, Hospital. 3. Bleaching Powder putting in all well & distribute the chlorine tablet to door to door & make awareness about the prevention of diseases to their community 4. Reporting to Director of Health (JD, AD, Epidemic, IDSP) & Collector of District									
3		diarrhoe a	block-pandariya, phc-chhirpani, sub centre -chiyadad, village-1.mangali, 2.chatari, 3.guda	32	3	03/0 7/20 09	11/0 7/20 09	1857	diarrhoe a	As above	As above									
4		diarrhoe a	block-pandariya, phc-chhirpani, sub centre -chiyadad, village-1.mangali,	42	4	03/0 7/20 09	13/0 7/20 09	3067	diarrhoe a	As above	As above									



[illegible]



8	SURGUJ A	Malaria	PHC Sanawal PHC Dindo Sector Sanawal and Dindo Village Trisuli ,Kundpan Pacawal , Duguru , Sundarpur and Tendua	79	4	03/1 1/20 09	10/1 1/20 09	28318	Continuo us Fever and Body ache	Blood Sample collected and tested at PHC Sanawal 74 case of PF malaria and 4 cases of PV malaria found	4 Health Camps organized at the different places under the supervision of Block Medical Officer, RRT team visited under the supervision of DSO Sarguja. Serious patient admitted to the PHC Sanawal and CHC Ramanujganj. , Mass Focal DDT Spraying at all affected villages and Mass Blood slides collection also going on at the village level  District RRT Team and combat team of CHC regularly visiting the village
9		Food Poisonin g	Chirmauhwa Village DandKarnwa Section Dand Karnwa PHC Ramkola Block Pratapapur District Sarguja Chhattisgarh	31	2	15/0 7/20 09	22/0 7/20 09	31	1. Stools from the Csaes2. Aquatic Sources in Village 3.Lower Economic	Sample Sent to District Hospital Ambikapu r, Result Awaited	Investigated by the District RRT team , Awareness given regarding the safe drinking water , personal hygiene , Disposal of Faecal Material , Distribution of chlorine tablets , Chlorination of water sources done by the village health worker, Diarrheal drugs distributed





**Online reporting based on S, P, L forms:**

There is considerable improvement in online reporting based on S, P, L forms as may be noted from the table given below. However, many of the figures displayed in the website for population, number reporting units for S, P, and L are not correct. Greater efforts will be put in to further improve the online reporting by more number of reporting units in timely manner with rectified figures for display.



Ministry of Health & Family Welfare, IDSP, Government of India													
Monthly Surveillance Report for Decision Makers for Chhattisgarh													
Summary Statistics for All SPL Diseases													
Date Report Generated :Jan 2, 2010 4:18:01 PM													
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Grass Roots Reported Cases Syndromic Surveillance(S)													
Acute Flaccid Paralysis <15 years Age	1	3	2	4	6	6	5	2	2	1	3	1	36
Cough with or Without fever (< 3 weeks)	22239	23072	24123	18205	17339	23027	24638	37300	32513	27191	34178	18378	302203
Cough with or Without fever (> 3 weeks)	781	1477	2220	1095	806	1180	1115	1406	1032	1276	1569	443	14400
Fever more than 7 days	430	320	590	364	281	368	420	603	898	624	1107	1669	7674
Fever<7 days (With Bleeding)	26	17	16	18	17	10	12	23	8	9	13	11	180
Fever<7 days (With Daze or Semi unconsciousness)	4	1	23	2	0	1	4	30	5	6	6	2	84
Fever< 7 days (Only Fever)	78603	88301	103336	77143	80653	132430	119461	185153	157840	125687	151083	77022	1376712
Fever< 7 days (With Rash)	133	230	483	304	210	117	318	274	331	207	257	71	2935
Jaundice < 4 Weeks	25	27	19	15	11	20	15	37	52	28	26	14	289



Loose Watery stool < 2 Weeks (With Some/Much Dehydration)	6715	7407	9001	7730	8567	12808	14436	17961	13084	8597	9221	5330	120857
Loose Watery stool < 2 Weeks (With no Dehydration)	13179	13509	16614	15418	16631	22647	22233	29384	22200	16612	17587	8800	214814
Loose Watery stool < 2 Weeks (With blood)	759	1294	1855	1310	1382	1927	2217	3504	2097	1195	961	337	18838
Unusual Symptom leading to death or hospitalization	0	16	0	1	8	10	17	88	54	13	1	5	213
Case Reported By Physician Presumptive Surveillance(P)													
Acute Diarrhoeal Disease (including acute gastroenteritis)	13	575	2633	3657	4825	8087	9924	13352	10414	6905	6863	3174	70422
Acute Encephalitis Syndrome	0	12	8	1	4	65	20	35	318	0	60	6	529
Acute Respiratory Infection (ARI) / Influenza Like Illness (ILI)	0	1580	5230	6585	7135	12197	12511	26672	21725	23924	28017	13431	159007
Any other State Specific Disease(Specify)	0	7	862	2310	2421	5963	5367	8090	8531	7597	9981	4157	55286



Acute Flaccid Paralysis < 15 Years of Age	0	11	9	30	3	5	7	33	12	7	31	57	205
Bacillary Dysentery	0	359	542	957	1812	2506	3802	5118	3428	2537	2213	1021	24295
Chikungunya	0	0	8	1	1	0	11	0	8	0	0	10	39
Chicken Pox	0	7	82	79	80	102	154	178	189	67	32	56	1026
Dog bite	0	1	176	147	228	359	274	313	245	277	552	264	2836
Dengue / DHF / DSS	0	28	23	9	85	19	9	32	36	16	444	34	735
Diphtheria	0	3	2	0	2	2	1	0	0	2	2	0	14
Enteric Fever	4	4451	726	1739	3950	4997	4941	10125	8010	7356	5908	2282	54489
Leptospirosis	0	0	3	2	3	20	17	14	34	33	16	4	146
Meningitis	0	12	11	0	6	13	12	2	1	0	0	1	58
Malaria	0	390	1485	1743	3607	4633	6404	11432	10185	7930	8439	3671	59919
Measles	0	32	12	6	21	8	9	15	38	244	16	3	404
Pneumonia	0	6	181	207	232	375	474	599	828	856	972	524	5254
Pertussis	0	1	7	0	2	26	55	58	36	6	11	12	214
Fever of Unknown Origin (PUO)	110	1573	7779	9516	9861	17941	20360	43580	38316	33027	34591	15499	232153
Snake bite	0	0	14	12	32	89	140	613	107	119	69	73	1268
Unusual Syndromes NOT Captured Above (Specify)	0	21	293	1205	1322	2502	2561	3207	1774	3782	10800	4813	32280



clinical)																			
Viral Hepatitis	0	9	40	48	87	270	167	826	1182	226	151	73	3079						
Case Reported By Lab(Laboratory Surveillance-L)																			
Cholera	0	0	0	0	0	0	3	0	0	0	1	0	4						
Dengue/DHF/DSS	0	0	0	0	0	0	0	0	0	0	0	0	0						
Diphtheria	0	0	0	8	0	0	0	16	0	3	0	0	27						
Chikungunya	0	0	0	0	0	0	0	0	0	0	0	0	0						
JE	0	0	0	0	0	5	2	1	1	0	0	0	9						
Leptospirosis	0	0	0	0	0	0	0	0	0	1	0	0	1						
Malaria	35	753	717	1759	1837	2654	4257	9651	7896	7218	7709	5281	49767						
Meningococcal Meningitis	0	0	14	6	4	9	2	0	2	0	0	6	43						
Shigella Dysentery	0	0	0	0	0	0	0	19	1	0	1	0	21						
Typhoid Fever	5	6	112	156	371	716	937	1902	1448	1258	745	199	7855						
Viral Hepatitis A	0	0	0	0	1	1	2	5	5	2	1	0	17						
Viral Hepatitis E	0	0	0	0	0	0	0	0	0	0	0	0	0						



**Financial Progress**

<b>Statement of Fund Position in 2009-10 and balance available for 2010-11.</b>			
<b>S. No.</b>	<b>Fund Position Heads</b>	<b>Amount In Rupees</b>	<b>Remark</b>
1	PIP Balance shown for 2009-10	12,500,000	By Central Unit
2	Advances for year 2009-10	881,604	As per Audit 2008-09
3	Total Bank and Cash Balance available with SSU	2,928,505	As per Audit 2008-09
4	Total Bank and Cash Balance available with DSUs	10,603,368	As per Audit 2008-09
5	Bank Interest received at SSU	95,292	Up to 30Sep'2009
6	Bank Interest received at DSUs	120,070	Up to 30Sep'2009
7	Total Bank and Cash Balance Available for utilisation in 2009-10	13,747,235	Up to 30Sep'2009
8	Funds utilised till 30th Sep'2009.	4,288,302	As per SOE
9	Funds that can be utilised by 31st March'2010.	7,062,500	Shown in Annexure
10	Cash & Bank Balance for year 2010-11	2,396,433	

For further detail kindly see the Annexure



*However, Chhattisgarh is a state with inadequate physical infrastructure and human resources, working in sparsely populated areas residing in geographically difficult terrain further affected with Naxalite problem. Due to these, the progress in the project is below satisfactory level. In addition, the Ministry of Health and Family Welfare has noted:*

*“At the time of launch of the IDSP certain critical assumptions were made about the surveillance infrastructure at the State and district levels that:*

- These units have adequate skills, resources and authority to respond.*
- Communities and private sector have adequate incentive to participate.*
- Laboratory information is of good quality, available in a timely manner and integrated into the surveillance system.*

*Over the past 4 years of implementation experiences with the project proved that these assumptions were not fully correct. For this reason, the Project Development Objectives (PDOs) could not be achieved and the fund utilization was low.....”*

*We are hopeful that the progress in the following year will be more substantial. The proposal for next year is based on the format provided by the Ministry of Health and Family Welfare.*



## **The Plan for the year 2010 – 11**

The project implementation plan for the year 2010 – 11 is based on the Modified Project Development Objectives (PDO) for 2010-2012 based on the report of World Bank Joint Implementation Support Mission review which took place in January 2009.

**Modified Project Development Objectives (PDO) for 2010-2012:**

Chhattisgarh commits itself to support the first phase of India's long run vision to improve and integrate disease surveillance compliant with the IHR 2005 requirement by:

- I. Supporting a state-wide effort for surveillance preparedness for immediate reporting of outbreaks, regular surveillance and weekly reporting with emphasis on provisional diagnosis by medically trained staff from public and private sectors to generate early warning signals for appropriate and timely public health actions.
- II. Demonstrating establishment and operation of decentralized surveillance systems meeting performance standards (timeliness, improved quality of outbreak investigation including mobilizing the human and other appropriate samples for confirming the diagnosis by laboratory network, Strengthening analysis and use of surveillance data and response) in Chhattisgarh.

The outcome indicators pertaining to above-mentioned modified project development objectives for **Chhattisgarh** are summarized in table below:

Components	Indicators for each component
Surveillance preparedness:	<ul style="list-style-type: none"> <li>• 60% of districts having full-time epidemiologists</li> <li>• 60% of districts with fully functional IT systems with on-line data entry and analysis</li> <li>• 60% of districts having systems in place for SOS reporting (Toll Free Number, Media Scanning etc.).</li> <li>• 25% of referral laboratories &amp; priority laboratories undertaking routine laboratory surveillance.</li> <li>• 25% of referral laboratories meeting the EQAS standards.</li> </ul>
Outbreak investigation and Response	<ul style="list-style-type: none"> <li>• 25% Outbreaks detected by system within one week of first case diagnosis.</li> <li>• 60% Outbreaks/rumours reported by other systems/media verified within 48 hours (documented in electronic register).</li> <li>• 25% of outbreaks for which adequate specimens reached the laboratory.</li> <li>• 25 % of reported outbreaks for which full documentation (first</li> </ul>



	<i>and final investigation reports) is available with SSU, IDSP.</i>
<i>Analysis and use of data</i>	<ul style="list-style-type: none"> <li>• <i>60% districts undertaking weekly surveillance analysis of data including graphs for trends over time and maps for incidence by area.</i></li> <li>• <i>60% districts providing monthly feedback (one page bulletin/news letter) to sub units, policy makers and general public.</i></li> </ul>

### **Detailed Project Description**

**Component 1: Strengthening state-wide improvements in Surveillance Preparedness to ensure compliance with IHR-2005:**

- *SSU would be monitoring outbreak investigation frequency, availability and utilization of laboratory confirmation.*
- *Further training for state/ district epidemiologists, data managers and data entry operators on appropriate use of the online idsp portal (confirming and enhancing portal functioning) and related analytic skills will provide needed analytic capacity at the state / district level.*
- *With the approval of modified P and L forms for IDSP, there would be definite improvement in quality and timeliness of reporting. New P and L forms were uploaded in portal. The rollout of the new forms to the districts has been carried out.*

**Component 2: Demonstrating timeliness and improved quality of outbreak investigation and response in all districts:**

- *The SSU would use the expanded variables developed by CSU to collect systematically the Outbreak Reporting System. SSU would also continuously monitor the data collected by this system, and work with the districts if the SSU identify evident problems with timeliness of reporting, laboratory confirmation, and appropriate interventions will be ensured.*
- *The 1075 call centre will be publicized to health professionals, and would particularly serve as an important supplement source of information and outbreaks in areas where surveillance infrastructure is yet to develop.*
- *Similarly, the media scanning service would serve as an important supplement in areas where surveillance infra-structure is still under development.*
- *Outbreaks reported and responded by IDSP system would be subjected to competency assessment tool developed by CSU for this purpose.*
- *Medical colleges would be involved in disease surveillance and response*



**Component 3: Strengthening analysis and use of surveillance data in 18 districts of Chhattisgarh demonstrating quality data analysis and assessing analytic quality of outbreak investigations:**

- Epidemiologists in SSU / DSU would formally review a sample of outbreaks reported using the suitably adapted assessment tool created for the outbreak investigation module.
- SSU / DSU epidemiologists would undertake analyses of IDSP data to better understand data contained in the system.
- Interesting and well conducted outbreak investigations would be actively used as models-e.g. through write-ups in IDSP bulletins, presentations on teaching and video-conferences.

#### **Proposed activities under different components**

- DSUs at Narayanpur and Bijapur needed to be established whenever the CMHO offices are established.
- Surveillance Preparedness:
  - Coordinate training of epidemiologists (district and State), microbiologist and (State and priority labs) and entomologists through NHSRC.
  - Involve the Medical Colleges in IDSP activity.
  - Refresher Training of District Surveillance Teams.
  - Additional Training for improved reporting and decentralized analysis will be done for health supervisors, block health management teams, pharmacists etc. This is a key activity to be taken up fresh. The pharmacists, Lab Technicians, Nurses attached to sub-district, district and Medical college hospitals will be trained in simple tasks of collating the data from multiple OPDs, in patients and laboratory and preparing weekly report to be shared with DSU.
- Ensuring fully functional IT systems in Place:
  - Recruitment and management of the IT Human Resource (DMs and DEOs) will be undertaken at State level, to expedite the process and fill the vacancies.
  - To promote the use of the toll-free services, the number will be publicized amongst health providers in conferences of IMA, IAP, private hospitals and amongst the general public by tagging to other information and



dissemination opportunities such as advertisements, bulletins on public health etc.

- The non-functional IT equipments related to IDSP like, UPS, scanner, fax, printer etc. will be either repaired or replaced by new one if it is irreparable to ensure smooth functioning by utilising budget allocated under miscellaneous head.

- For Priority labs:

- Procurement of equipments will be expedited through rigorous monitoring at state level.
- Procurement of quality kits at state level based on the revised guidelines developed by the CSU.
- Maintenance of the lab equipments will be ensured through DSUs.
- Develop a specimen collection system within the district.
- To prepare and distribute SOP manuals for the district priority labs inclusive of bio waste management guidelines and mechanisms for internal quality controls.
- monitoring of the functioning of priority labs

- Strengthening of outbreak investigation and response at district and peripheral level:

- Mitanins will be provided with incentives for reporting any outbreak.
- 25% Outbreaks detected by system within one week of first case diagnosis at district.
- 60% Outbreaks/rumours reported by other systems/media verified within 48 hours (documented in electronic register).
- 25% of outbreaks for which adequate specimens reached the priority laboratories.

- Analysis and use of data:

- 50% districts undertaking weekly surveillance analysis of data including graphs for trends over time and maps for incidence by area.
- 60% districts providing monthly feedback (one page bulletin/news letter) to sub units, policy makers and general public.



**Proposed IDSP budget for Chhattisgarh for the Year 2010-11**

Activity	Tasks	Level	Unit Cost	No. of Units	Multiplying factor / No. of Months	Budget for 2010-11 (in lakh)	Remarks
1. Staff Salary	1.1	Epidemiologists	State & District	30000	19	12	At 18 DSUs + SSU
	1.2	Microbiologists	State & District	20000	2	12	1 at SSU + 1 Pt. JNM Medical College, Raipur
	1.3	Entomologist	State Level	20000	1	12	At SSU
	1.4	Consultant (Finance)	State Level	18000	1	12	At SSU
	1.5	Consultant (Training)	State Level	28000	1	12	As per the IDSP guidelines, there is provision of 28000 for Medical TC 14000 for Non-medical TC. However, the current non-medical TC will be provided Rs. 18000 per month
	1.6	State Data Manager		18000	1	12	At present, the salaries of the state and district data managers are being paid by CSU through NIC/ Outsourced Agency. Hence the budget for their salaries is excluded
	1.7	District Data Manager		16000	18	12	



Proposed IDSP budget for Chhattisgarh for the Year 2010-11

Activity	Tasks	Level	Unit Cost	No. of Units	Multiplying factor / No. of Months	Budget for 2010-11 (in lakh)	Remarks	
	1.8	Data Entry Operators	State & District	9200	20	12	22.08	2 at SSU + 18 at DSUs
	1.9	District Accountants	District Level	11000	18	12	23.76	At 18 DSUs
	1.10	Administrative Assistants	District Level	9200	19	12	20.976	At 18 DSUs + SSU
	1.11	Helper	State Level	4500	1	12	0.54	At SSU
2. Training	2.1	Training of Hospital Doctors	District Level	36500	23	1	8.40	Total 460 Medical Officers of districts Raipur, Bilaspur, Koriya, Kawardha, Mahasamund, Dhamtari, Janjgir and Dantewada will be trained in batches of 20 each at district level
	2.2	Training of Hospital Pharmacists / Nurses	District Level	15500	40	1	6.2	Total 800 Pharmacists & Nurses. 20 persons per batch



**Proposed IDSP budget for Chhattisgarh for the Year 2010-11**

Activity	Tasks	Level	Unit Cost	No. of Units	Multiplying factor / No. of Months	Budget for 2010-11 (in lakh)	Remarks
2.3	Training of Data Managers / Data Entry Operators	State & District	62000	2	1	1.24	19 DM and 23 DEO will be trained in 2 batches for duration of 6 days. Each batch will have approximately 20 persons. This activity will be carried out at state level subject to approval from the CSU, IDSP as per its revised guidelines regarding Modified Project Development Objectives
2.4	Training of peripheral lab technicians	State & District	18000	5	1	0.9	The training will be conducted in batches of 20 lab technicians for the remaining 36 District Level and 60 block level LT
2.5	Workshop for Medical Officers and Health Workers on Swine Flu	State & District	30000	164	1	49.2	1-day workshop will be organised for MO and Health Workers for each of the CHC, DH & Medical Hospitals



Proposed IDSP budget for Chhattisgarh for the Year 2010-11

Activity	Tasks	Level	Unit Cost	No. of Units	Multiplying factor / No. of Months	Budget for 2010-11 (in lakh)	Remarks	
3. Operational Costs	3.1	Mobility Support	State & District	5000	19	12	11.4	For SSU & 18 DSUs, including hiring of vehicles, POL & Hiring of Driver on daily wages in case vehicle being provided the Department
	3.2	Office Expenses	State Level	350000	1	1	3.5	As per IDSP Guidelines at for respective levels for one year
		District Level	130000	18	1	1	23.4	
		Peripheral Level	15000	146	1	1	21.9	
	3.3	ASHA incentives for outbreak reporting	District & Peripheral Level	100	2160	1	2.16	120 per information per district for 18 districts
	3.4	Consumables for Priority Labs.	State Level	200000	1	1	2	As per IDSP Guidelines at for respective levels for one year. All procurement will be carried out at State Level
			District Level	100000	18	1	18	
Peripheral Level			10000	146	1	14.6		



**Proposed IDSP budget for Chhattisgarh for the Year 2010-11**

Activity	Tasks	Level	Unit Cost	No. of Units	Multiplying factor / No. of Months	Budget for 2010-11 (in lakh)	Remarks
	3.7	Printing of reporting forms	75	8000	1	6	8000 pads (Pages 56 x 3) Form S, P & L. Printing of S, P, L forms will be carried out at State Level
	3.8	Broadband expenses	1000	19	12	2.28	18 districts + 1 SSU
	3.9	Miscellaneous including contingency	50000	1	1	0.5	Amount proposed as per IDSP guidelines
4. New Innovations	4.1	Involving hospitals of Central Government, Undertakings, Corporate Sector & Private Nursing Homes of Major Towns	20000	18	1	3.6	One day orientation of medical and paramedical staff of the mentioned public and private sector hospitals will be conducted in Raipur, Bhilai-Durg, Bilaspur, Raigarh, Korba & Jagadalpur
			75000	6	1	4.5	
5. IEC	5.1	IEC Activities for awareness and sensitisation of people regarding	300000	1	1	3	Activities of disseminating information on communicable diseases to raise awareness will be undertaken through
			100000	18	1	18	



Proposed IDSP budget for Chhattisgarh for the Year 2010-11

Activity	Tasks	Level	Unit Cost	No. of Units	Multiplying factor / No. of Months	Budget for 2010-11 (in lakh)	Remarks
6. Swine Flu / Epidemic Situation	communicable diseases like swine flu and others						advertisement in daily newspapers, posters, pamphlets, banners, hoardings and electronic media
	5.2 IDSP reports including alerts		10	10000	2	2	Half yearly bulletins will be published
	6.1 Sample Collection and Transportation	State Level	1000	1	365	3.65	The fund will be used for swine flu or other epidemics
	6.2 Mobility Support for tracing the patients administering medicines, transport of medicine etc.	CMHO	20000	18	1	3.6	
		DH	20000	18	1	3.6	
6.3	Logistics - PPE, VTM, N-95, 3M, Packing materials	State Level	1000000	1	1	10	The procurement will be made at state level.
		District Level	100000	18	1	18	



**Proposed IDSP budget for Chhattisgarh for the Year 2010-11**

Activity	Tasks	Level	Unit Cost	No. of Units	Multiplying factor / No. of Months	Budget for 2010-11 (in lakh)	Remarks
	6.4	Medicines like Tamiflu tablets and syrup in kind support from the GOI					The supply will be obtained from the Government of India.
<b>Grand Total</b>						<b>390.10</b>	



## Annexure I

**DIRECTORATE OF HEALTH SERVICES**  
**INTEGRATED DISEASE SURVEILLANCE PROJECT**  
**CONSOLIDATED REPORT OF SUB SOCIETY- IDSP CHHATTISGARH**  
**Component wise Actual Expenditure and Provisional Expenditure for remaining six months (01st Oct,09 to 31st March,2010) :-**

Sl. No.	District	Opening Balance (01.04.09)	Advance Given by DSUs Last Year	Actual Balance in year	EXPENDITURE (Up to 30th Sep2009)			Balance Fund (Cash & Bank)	Received Interest	Total Balance up to 30th Sep2009	Provisional Expenditure in Approved Activities Upto 31st March'2010.					Balance may be utilised in next Financial Year
					Qtr.-I	Qtr.-II	Total				Laboratory Equipments	IEC Costs	Contractual Staff	Operational Cost	Total	
1	Bastar	666,754	0	666,754	73,588	224,562	298,150	368,604	0	368,604	NA	NA	0	130,000	130,000	238,604
2	Bilaspur	787,792	9,619	778,173	69,042	138,029	207,071	571,102	2,101	573,203	NA	NA	378,000	65,000	443,000	130,203
3	Dantewada	756,993	0	756,993	61,060	123,414	184,474	572,519	10,045	582,564	NA	NA	360,000	130,000	490,000	92,564
4	Dhamtari	466,899	14,600	452,299	89,739	126,967	216,706	235,593	0	235,593	NA	NA	228,000	65,000	293,000	-57,407
5	Durg	754,095	140,000	614,095	65,835	74,117	139,952	474,143	9,078	483,221	NA	NA	138,000	65,000	203,000	280,221
6	Janjgir	662,849	0	662,849	15,000	139,101	154,101	508,748	7,057	515,805	NA	NA	294,000	65,000	359,000	156,805
7	Jashpur	508,319	0	508,319	57,562	248,824	306,386	201,933	5,226	207,159	NA	NA	396,000	65,000	461,000	-253,841
8	Kanker	581,011	73,400	507,611	25,854	96,144	121,998	385,613	7,052	392,665	NA	NA	54,000	65,000	119,000	273,665
9	Kawardha	607,114	415,070	192,044	0	145,821	145,821	46,223	7,307	53,530	NA	NA	264,000	65,000	329,000	-275,470
10	Korba	693,162	10,000	683,162	28,000	105,330	133,330	549,832	9,161	558,993	NA	NA	264,000	65,000	329,000	229,993
11	Korla	1,193,032	0	1,193,032	22,955	405,009	427,964	765,068	19,119	784,187	NA	NA	318,000	65,000	383,000	401,187
12	Mah'mund	393,873	3,314	390,559	63,211	173,551	236,762	153,797	3,677	157,474	NA	NA	354,000	65,000	419,000	-261,526
13	Raigarh	552,516	0	552,516	144,633	16,450	161,083	391,433	0	391,433	NA	NA	300,000	65,000	365,000	26,433
14	Raipur	1,406,445	193,129	1,213,316	50,128	212,161	262,289	951,027	21,346	972,373	NA	NA	312,000	65,000	377,000	595,373
15	Rajn'dgon	547,953	0	547,953	46,759	183,621	230,380	317,573	5,856	323,429	NA	NA	348,000	65,000	413,000	-89,571
16	Sarguja	883,693	0	883,693	22,480	449,006	471,486	412,207	13,045	425,252	NA	NA	324,000	65,000	389,000	36,252
Sub Total		11,462,500	859,132	10,603,368	835,846	2,862,107	3,697,953	6,905,415	120,070	7,025,485	0	0	4,332,000	1,170,000	5,502,000	1,523,485
17	SSU C.G.	2,950,977	22,472	2,928,505	127,903	462,446	590,349	2,338,156	95,292	2,433,448	530,000	150,000	630,500	250,000	1,560,500	872,948
Grand Total		14,413,477	881,604	13,531,873	963,749	3,324,553	4,288,302	9,243,571	215,362	9,458,933	530,000	150,000	4,962,500	1,420,000	7,062,500	2,396,433



**DIRECTORATE OF HEALTH SERVICES**  
**INTEGRATED DISEASE SURVEILLANCE PROJECT**  
**CONSOLIDATED REPORT OF SUB SOCIETY- IDSP CHHATTISGARH**  
**Statement for Consultant / Contractual Staff Salary Payment for Financial Year 2009-10 (Upto 31st March' 2010) :-**

Sl. No.	SSU Staff	Sanctioned Staff	Position in Staff	Salary Per Month in Rs.	Provisional for Salary Payment						Remark
					Payable from Oct.09 to March.2010		Arears payable from 01st April.09 to 30th Sep.2009		Payable Amount	Total Payment	
					No of Months	Payable Amount	No of Months	Old Salary			
1	Epidemiologist	1	1	34,000	6 month	204,000	6 month	25,000	54,000	258,000	-
2	Microbiologist	1	1	15,000	6 month	90,000	6 month	15,000	0	90,000	-
3	Entomologist	1	0	17,500	-	-	5 month	15,000	12,500	12,500	Resined on dated 17th August 2009
4	Consultant Training	1	1	14,000	6 month	84,000	6 month	10,000	24,000	108,000	-
5	Consultant Finance	1	1	14,000	6 month	84,000	6 month	10,000	24,000	108,000	-
6	Data Manager	1	1	14,000	-	-	-	10,000	-	-	Salary paid by NiC Delhi
7	Data Entry Operator	2	0	8,500	-	-	-	6,000	-	-	-
8	Administrative Assistants	1	1	7,000	6 month	42,000	6 month	5,000	12,000	54,000	-
9	Helper	1	0	4,500	-	-	-	3,000	-	-	-
Grand Total		10	6	128,500	Sub Total	504,000	Sub Total	99,000	126,500	630,500	-



**DIRECTORATE OF HEALTH SERVICES**  
**INTEGRATED DISEASE SURVEILLANCE PROJECT**  
**CONSOLIDATED REPORT OF SUB SOCIETY- IDSP CHHATTISGARH**

Statement for Consultant / Contractual Staff Salary Payment for Financial Year 2009-10 (As on 31st March 2009) :-

Sl. No.	District Staff	Epidemiologists		Microbiologist		Data Managers		Accountant		Data Entry Operator		Administrative Assistants		Provisional for Salary Payment						Remark
		No of Workin g Staff	Rs. Per Month	No of Working Staff	Rs. Per Month	No of Working Staff	Rs. Per Month	No of Working Staff	Rs. Per Month	Payable from Oct.09 to March.2010			Areas payable from 01st April.09 to 30th Sep.2009			Total Salary Payable Amount in Year				
										No of Months	Salary payable per month	Payable Amount	No of Months	Rs @ per month	Payable Amount					
1	Bastar	0	28,000			1	13,500	0	9,500	0	8,500	0	7,000	6 month	0	0	0	0	DM salary paid by NIC Delhi	
2	Narayanpur	0	30,500				13,500		9,500		8,500	0	7,000	6 month	0	0	0	0		
3	Bilaspur	1	28,000			1	13,500	1	9,500	1	8,500	1	7,000	6 month	53,000	318,000	6 month	10,000	378,000	DM salary paid by NIC Delhi
4	Dantewada	0	28,000			1	13,500	1	9,500	1	8,500	1	7,000	6 month	25,000	150,000	6 month	7,000	192,000	DM salary paid by NIC Delhi
5	Bijapur	1	26,500				13,500		9,500		8,500		7,000	6 month	26,500	159,000	6 month	1,500	168,000	DM salary paid by NIC Delhi
6	Dhamtari	1	26,000			1	13,500	0	9,500	1	8,500	0	7,000	6 month	34,500	207,000	6 month	3,500	228,000	DM salary paid by NIC Delhi
7	Durg	0	29,000			1	13,500	1	9,500	1	8,500	0	7,000	6 month	18,000	108,000	6 month	5,000	138,000	DM salary paid by NIC Delhi
8	Janjgir	1	27,000			1	13,500	0	9,500	1	8,500	1	7,000	6 month	42,500	255,000	6 month	6,500	294,000	DM salary paid by NIC Delhi
9	Jashpur	1	29,500			1	13,500	1	9,500	1	8,500	1	7,000	6 month	54,500	327,000	6 month	11,500	396,000	DM salary paid by NIC Delhi
10	Kanker	0	28,500			1	13,500	0	9,500	0	8,500	1	7,000	6 month	7,000	42,000	6 month	2,000	54,000	DM salary paid by NIC Delhi
11	Kawardha	1	30,000			1	13,500	0	9,500	0	8,500	1	7,000	6 month	37,000	222,000	6 month	7,000	264,000	DM salary paid by NIC Delhi
12	Korba	1	29,000			1	13,500	1	9,500	1	8,500	0	7,000	6 month	37,500	225,000	6 month	6,500	264,000	DM salary paid by NIC Delhi
13	Koria	1	33,000			0	13,500	1	9,500	0	8,500	0	7,000	6 month	42,500	255,000	6 month	10,500	318,000	DM salary paid by NIC Delhi
14	Mah'mund	1	26,000			1	13,500	1	9,500	1	8,500	1	7,000	6 month	51,000	306,000	6 month	8,000	354,000	DM salary paid by NIC Delhi
15	Raigarh	1	26,000			1	13,500	1	9,500	1	8,500	0	7,000	6 month	44,000	264,000	6 month	6,000	300,000	DM salary paid by NIC Delhi
16	Raipur	1	27,000	0	16,000	1	13,500	1	9,500	1	8,500	0	7,000	6 month	45,000	270,000	6 month	7,000	312,000	DM salary paid by NIC Delhi
17	Rajn'dgon	1	30,000			1	13,500	1	9,500	1	8,500	0	7,000	6 month	48,000	288,000	6 month	10,000	348,000	DM salary paid by NIC Delhi
18	Sarguja	1	29,000			1	13,500	1	9,500	0	8,500	1	7,000	6 month	45,500	273,000	6 month	8,500	324,000	DM salary paid by NIC Delhi
Grand Total		13	511,000	0	16,000	15	243,000	10	171,000	11	#####	8	126,000		611,500	3,669,000	0	110,500	4,332,000	



**DIRECTORATE OF HEALTH SERVICES, CHHATTISGARH**  
**INTEGRATED DISEASE SURVEILLANCE PROJECT**  
**Administrative Approval For Quarter Three And Four For Financial Year 2009-10**

S. No.	District	Administrative Approval for the period of Oct'2009 to Mar'2010					Funds Available with DSUs (As on 30-09-2009)			Excess / Shortage of Fund	Excess Fund	Shortage Fund
		Lab. Equip. & Consumables	Training	IEC	Consultant / Contractual	Operational Cost	Total Approved Budget	IDSP Fund	EUSPP Fund	Total Fund		
1	Bastar & Narayanpur	0	0	0	461,750	130,000	591,750	352,228	108,074	460,302	131,448	0
2	Bilaspur	0	0	0	304,000	65,000	369,000	441,892	15,000	456,892	87,892	0
3	Dantewada & Bilaspur	0	0	0	449,750	130,000	579,750	424,514	0	424,514	155,236	0
4	Dhamtari	0	0	0	293,000	65,000	358,000	236,092	0	236,092	121,908	0
5	Durg	0	0	0	309,500	65,000	374,500	391,871	15,000	406,871	32,371	0
6	Janjgir	0	0	0	298,500	65,000	363,500	536,229	0	536,229	172,729	0
7	Jashpur	0	0	0	312,250	65,000	377,250	84,676	9,905	94,581	282,669	0
8	Kanker	0	0	0	306,750	65,000	371,750	525,840	0	525,840	154,090	0
9	Kawardha	0	0	0	305,000	65,000	370,000	607,457	0	607,457	237,457	0
10	Korba	0	0	0	309,500	65,000	374,500	486,993	0	486,993	112,493	0
11	Koria	0	0	0	331,500	65,000	396,500	737,187	0	737,187	340,687	0
12	Mahasamund	0	0	0	293,000	65,000	358,000	52,719	35,000	87,719	270,281	0
13	Raigarh	0	0	0	293,000	65,000	358,000	218,206	0	218,206	139,794	0
14	Raipur	0	0	0	376,500	65,000	441,500	1,358,631	0	1,358,631	917,131	0
15	Rajnandgaon	0	0	0	315,000	65,000	380,000	221,929	0	221,929	158,071	0
16	Sarguja	0	0	0	309,500	65,000	374,500	425,252	0	425,252	50,752	0
	<b>Sub Total</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>5,268,500</b>	<b>1,170,000</b>	<b>6,438,500</b>	<b>7,101,716</b>	<b>182,979</b>	<b>7,284,695</b>	<b>-846,195</b>	<b>1,259,407</b>
17	SSU, Raipur	530,000	0	150,000	875,000	250,000	1,805,000	1,769,185	40,000	1,809,185	4,185	0
	<b>Grand Total</b>	<b>530,000</b>	<b>0</b>	<b>150,000</b>	<b>6,143,500</b>	<b>1,420,000</b>	<b>8,243,500</b>	<b>8,870,901</b>	<b>222,979</b>	<b>9,093,880</b>	<b>-850,380</b>	<b>1,259,407</b>



## F- NVBDCP

### F. NATIONAL VECTOR BORNE DISEASE CONTROL PROGRAMME

#### 1. Situation analysis of the disease.

Table Indicating of High risk Districts and population as on 2008

Sl. No.	Name of Districts	Total no of CHCs / Blocks	No. of High Risk CHCs / Blocks (API 2 & more)	% of CHCs / Blocks at high risk	Total Population	Population at high risk	% of population at high risk
1	Raipur	16	2	12.50%	3460299	364333	10.52%
2	Bastar	14	14	100%	1343515	13,43,515	100%
3	Sarguja	19	18	94.70%	2434998	23,05,943	94.69%
4	Durg	13	1	7.60%	3283342	190698	5.8%
5	Dhamtari	4	1	25%	771738	221086	28.64%
6	Bilaspur	11	3	27.27%	2394057	465069	19.42%
7	Rajnandgaon	10	6	60%	1447062	8,68,237	59.99%
8	Raigarh	9	4	44.44%	1478784	535596	36.21%
9	Korba	5	5	100%	1159779	1159779	100%
10	Kanker	10	10	100%	755067	7,55,067	100%
11	Janjgir	9	1	11.11%	1637325	169075	10.32%
12	Korea	5	5	100%	657734	657734	100%
13	Kawardha	4	2	50%	768321	426946	55.56%
14	Mahasamund	5	nil	0%	1128158	nil	0%
15	Dantewada	11	11	100%	770049	770049	100%
16	Jashpur	9	9	100%	904715	904715	100%
TOTAL		154	92		24394943	11047142	



**B) Dedicated Staff Position of the State:**

DISTRICT	DMO			Assist. Malaria officer		
	Sanctioned	In Position	Vacant	Sanctioned	In Position	Vacant
Raipur	1	0	1	1	0	1
Dhamtari	1	0	1	1	0	1
Bilaspur	1	1	1	1	1	0
Jashpur	1	0	1	1	0	1
Raigarh	1	0	1	1	1	0
Ambikapur	1	0	1	1	1	0
Korba	1	0	1	1	1	0
Korea	1	0	1	1	1	0
Bastar	1	0	1	1	1	0
Dantewada	1	0	1	1	0	1
Kanker	1	0	1	1	1	0
MSD	1	0	1	1	0	1
DRUG	1	1	1	1	1	0
Rajnandgaon	1	0	1	1	1	0
Kawardha	1	0	1	1	0	1
Janjgir	1	0	1	1	0	1
Total	16	2	14	16	8	8

DISTRICT	VBD Consultant			MTSS		
	Allotted Post	Recommendation	In Position	Allotted Post	Recommendation	In Position
Raipur	1	1	1	3	3	3
Dhamtari	1	1	0	1	1	1
Bilaspur	1	1	1	2	2	2
Jashpur	1	1	1	5	5	4
Raigarh	1	1	1	3	3	3
Ambikapur	1	1	1	19	19	19
Korba	1	1	1	4	4	4
Korea	1	1	1	5	5	3
Bastar (including Narayanpur)	1	1	1	10	10	6



Dantewada (in-Bijapur)	1	1	1	10	5	1
Kanker	1	1	0	4	4	2
<b>TOTAL</b>	<b>11</b>	<b>11</b>	<b>9</b>	<b>66</b>	<b>61</b>	<b>48</b>

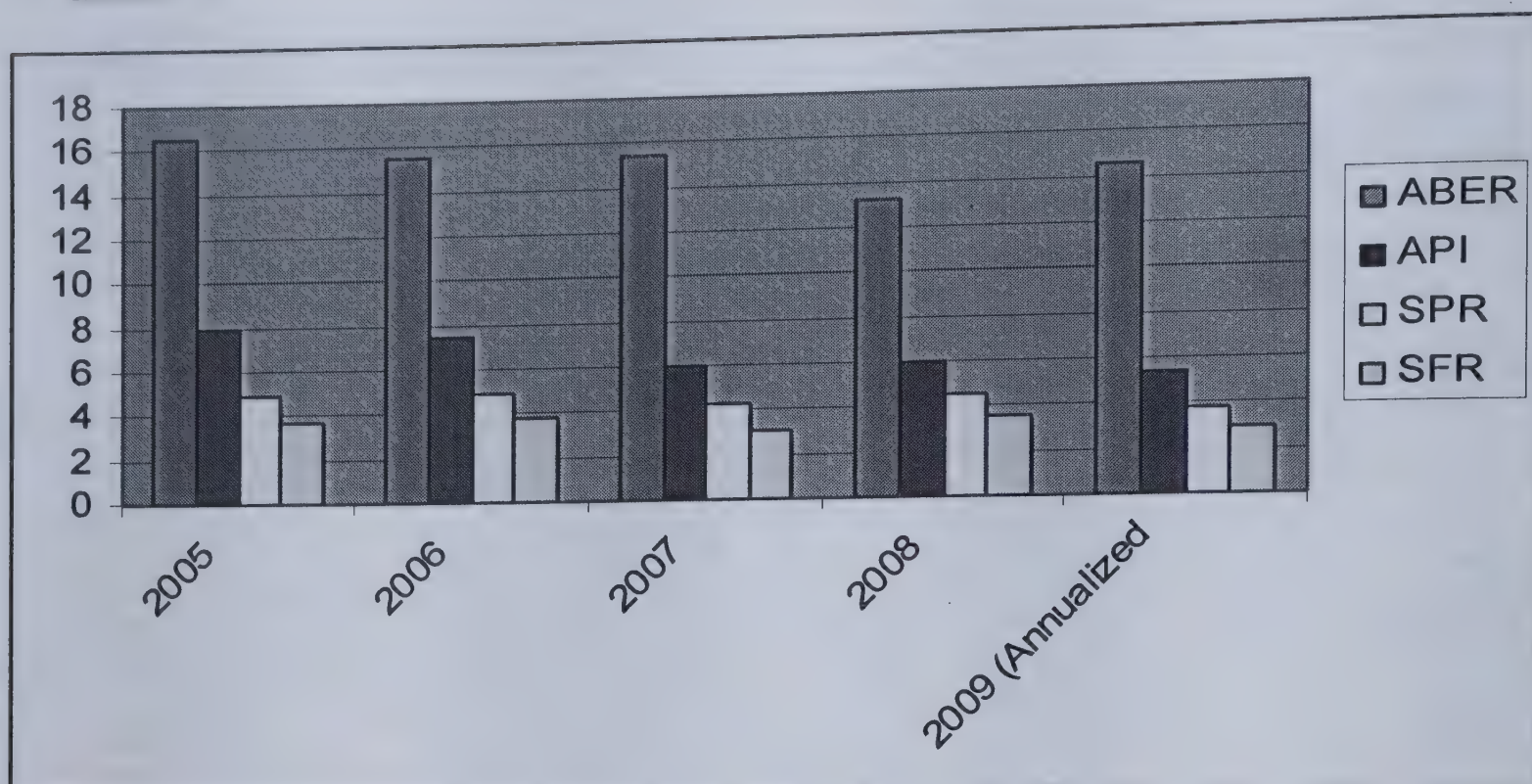
DISTRICT	LTs			MPWs		
	Allotted Post	Recomd-	In Position	Allotted Post	Recommendation	In Position
Raipur	3	3	2	0	0	0
Dhamtari	3	1	1	0	0	0
Bilaspur	3	3	3	0	0	0
Jashpur	3	3	2	170	170	165
Raigarh	3	3	3	75	75	75
Ambikapur	3	3	3	205	205	205
Korba	3	3	1	0	0	0
Korea	3	3	1	75	75	73
Bastar (including Narayanpur)	3	3	2	130	130	120
Dantewada (including Bijapur)	3	1	1	115	115	72
Kanker	3	2	2	60	60	60
<b>TOTAL</b>	<b>33</b>	<b>28</b>	<b>21</b>	<b>830</b>	<b>830</b>	<b>770</b>

C) Malaria is the major problem in Chhattisgarh state. In 2009 (up to November 2009) the ABER was 14.6, API 5.4, SPR 3.8 and SFR 2.94. The bar diagram below depicts the progress made in malaria control in the State.

#### **Epidemiological Situation of Malaria in Chhattisgarh State**

	2005	2006	2007	2008	2009 (Annualized)
ABER	16.51	15.51	15.38	13.23	14.6
API	8.01	7.53	5.95	6.06	5.4
SPR	4.85	4.9	4.23	4.58	3.8
SFR	3.62	3.8	3.11	3.59	2.94





**Malaria disease burden in Chhattisgarh state during 2008**

Name of districts	Population (%)	TPC (%)	PF (%)
Jashpur	3.80	7.92	10.26
Korba	4.33	7.44	3.73
Raigarh	5.99	5.08	4.33
Bastar	5.77	23.59	28.78
Ambikapur	9.87	9.20	7.37
Korea	2.67	7.88	5.36
Dantewada	3.32	20.82	23.56
Kanker	3.17	9.91	12.04
Mahasamund	4.57	0.39	0.26
Janjgir	6.60	0.29	0.23
Raipur	14.05	1.01	0.94
Durg	13.31	1.24	0.70
Bilaspur	9.70	1.68	1.20
Rajnandgaon	6.12	2.20	0.55
Dhamtari	3.59	0.54	0.40
Kawardha	3.15	0.81	0.29
Total	100%	100%	100%



Table 3. Malaria situation in Chhattisgarh State 2000-2008

Year	Pop	BSC	Pos	Pf	ABER	API	SPR	%Pf	SFR	Deaths
2000	21597236	4097160	361795	255430	19.0	16.8	8.8	70.6	6.2	63
2001	22547199	4010560	290666	201569	17.8	12.9	7.2	69.3	5.0	32
2002	23070123	3741796	245365	177100	16.2	10.6	6.6	72.2	4.7	3
2003	23469787	3693618	194419	144028	15.7	8.3	5.3	74.1	3.9	4
2004	23469487	3584059	186056	142867	15.3	7.9	5.2	76.8	4.0	6
2005	23469487	3874911	187950	140182	16.5	8.0	4.9	74.6	3.6	3
2006	23472985	3609628	176868	137008	15.38	7.53	4.90	77.46	3.80	3
2007	24547198	3447058	145949	107321	14.04	5.95	4.23	73.53	3.11	0
2008	24394943	3227877	147814	115773	13.23	6.06	4.58	78.32	3.59	4

#### D) Outbreak & containment measure taken

Area of Outbreak	Period	Reason	Measure taken	Death
Mahasamund district, Bag Bahara Block, Khilari sector and Beller Village (Affected areas)	26-10-2009 to 07-11-2009.	Ponds Dense forest Damp of Cow duck	Immediate manpower deputised. Contac slide preparation. Emergency treatment unit maintained. Focal DDT Spray	1
Sarguja District, Sanawal & Dondi PHC areas.	15-11-2009 to 30-11-2009	Patients did not respond to Choloroquine	Immediate manpower deputise. Contac slide preparation. Emergency treatment unit maintained. Focal DDT Spray	5



**E) No. of PHC without Lab Technician and Microscopy facilities**

S. No.	Name of District	No. of PHC	No. of PHC with functioning microscope	No. of PHCs with LTs	No. of village	No. of villages with ASHA
1	Ambikapur	86	23	23	1781	1781
2	Korea	27	17	3	656	656
3	Korba	5	5	5	692	2274
4	Durg	71	17	28	1805	1805
5	Dantewada	37	37	29	1214	1175
6	Raipur	16	16	12	2208	2208
7	Bilaspur	75	11	5	1610	1610
8	Kanker	28	23	23	1078	1078
9	Kawardha	23	NR	NR	NR	NR
10	Jashpur	45	13	13	765	765
11	Raigarh	90	9	8	1435	1435
12	Bastar	65	65	65	1510	5212
13	Dhamtari	21	7	7	633	633
14	Janjgir Champa	23	10	8	915	915
15	Rajnandgaon	43	18	0	NR	NR
16	Mahasamund	28	6	1	NR	NR
Total						

**2. Specific constrains for Implementation of the programme.**

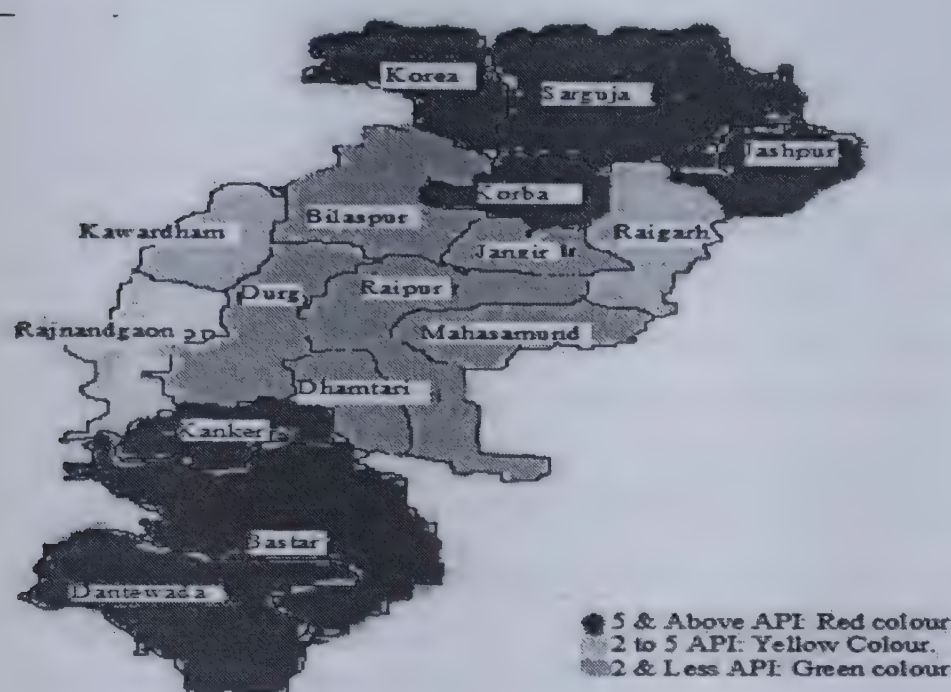
S. no	Problem / Constrain	Description of constrain	Possible solution
1	IRS Activities	The pump and machines are old and need to be replaced by new pumps.	Allocation of fund for Spray tools replacement. Involvement of private partners
2	Implementation of new drug policy	The new drug policy need to be implemented the private sector for better coverage of the programme.	Private practitioner, private clinic, Nursing home, NGOs and village level Quakes may involve with this programme for holistic coverage.
3	Full time DMO in the districts	Only 2 DMOs are working as full time in two district and	Engagement of Fulltime DMO may strengthen to programme



		others are involved for other responsibilities therefore they are not able to concentrated only in the Malaria control programme.	management.
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### 3. Prioritization of the areas including the criteria of prioritization.

As on 2008 data in terms of API.

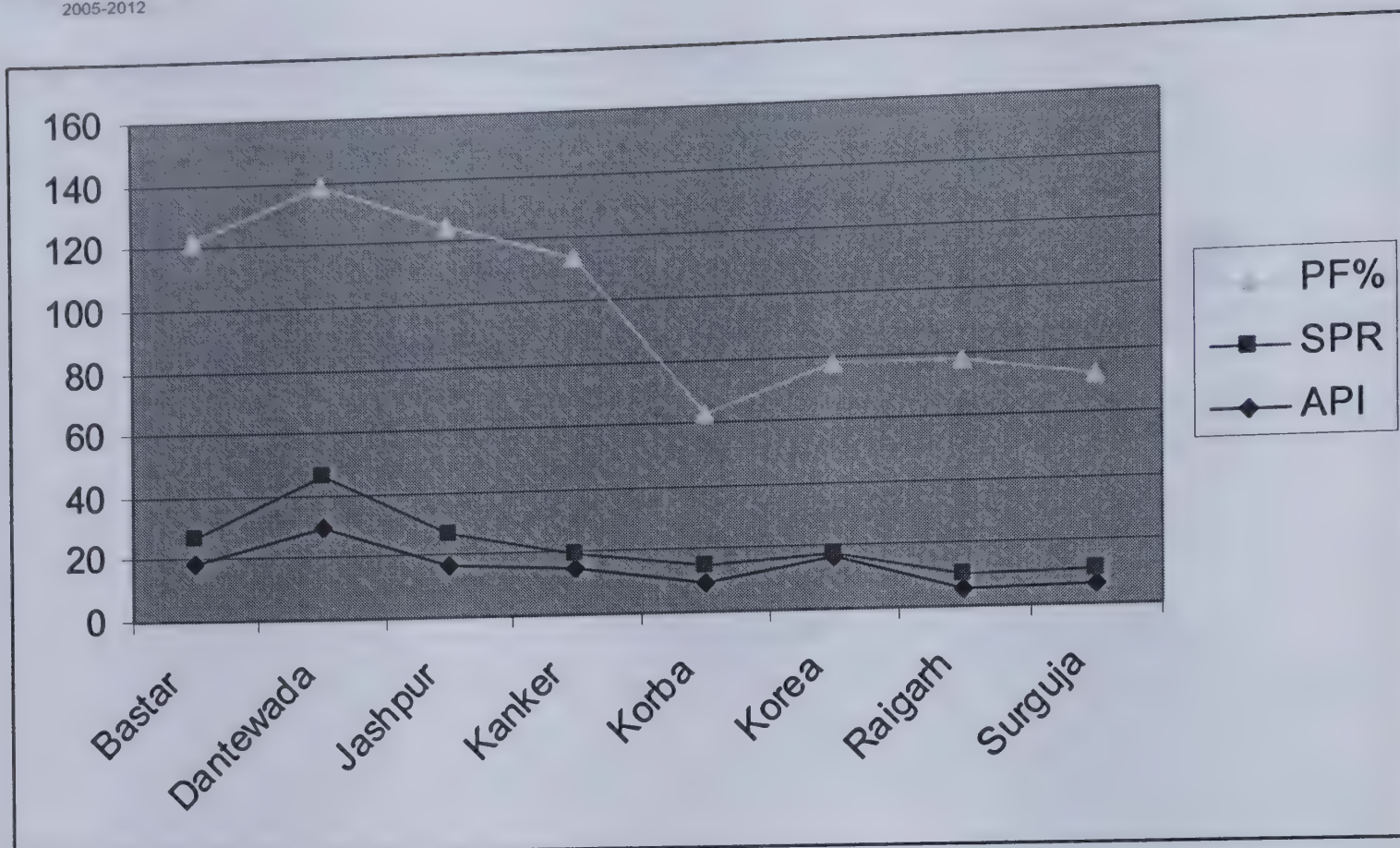


The high burden districts has been identified based on the following criteria (as on Nov'2009)

- High API, PF% & SPR rate.
- Geographical situation
- Hard to reach areas
- And backward class community.

District	API	SPR	PF%
Bastar	18.2	8.4	95.1
Dantewada	30	16.6	91.8
Jashpur	16.7	10.3	97.8
Kanker	14.8	4.4	94.1
Korba	9	5.8	48.2
Korea	16.6	1.2	60
Raigarh	6	4	67.7
Sarguja	6.2	4.5	61.6





### Major achievements of Enhanced Malaria Control Project (EMCP):

The major achievements under EMCP can be highlighted as under:

- 1) Reduction in malaria incidence in the entire state (Incidence of malaria has declined from 361795 malaria cases in 2000 to 147814 (40.85%) in 2008)

### Innovative measures taken up by the State

- 1) Areas reporting increase in fever incidence as per the weekly reports from the districts are being monitored on a day to day basis by deploying surveillance teams.
- 2) Intensive surveillance in high risk areas through team mode (pulse malaria campaigns) and follow up of malaria cases detected is being carried out during the transmission season in all the districts.
- 3) Biological control activities were intensified by involving Mitans (Asha Workers).
- 4) Treating community owned mosquito nets and making available more mosquito nets out of various sources was taken up as a priority.
- 5) Timely commencement of Indoor Residual Spray.
- 6) Awareness generation activities carried out during various local festivals and celebrations viz., Rajyotsav, Surguja Mahotsav, Bastar Mahotsav and several other village level melas, madai, nukkad plays and kalajathas.
- 7) 160000 LLIN have been distributed to pregnant women during village health & nutrition day. These LLIN are supplied by UNICEF.
- 8) During a month long campaign "Sishu Samrakshen Man" 2 lacks, 80 thousand bed net are impregnated. This campaign is integrated with RCH services.



9) Through electronic media Television and Akashwani messages percolated to take preventive measures for Malaria, Filaria, Dengue and Chikangunya.

**Situation specific activities proposed for the high-risk tribal areas in the state.**

1. State Health Resource Centre is imparting training to Mitnin for diagnosing Malaria fevers with Rapid Diagnostic Kits (RDK) and to treat the patients with therapeutic dose of ACT. Mitnin shall report complete cure of the patients or referral of the patients to health centres in the meeting of Village Health Nutrition Day. MPW shall record the report of Mitnin in Mitnin Diary and accordingly Mitnin shall be paid Rs.20 against the services rendered to the patients.
2. Establishing FTDs or alternatively DDCs in all the villages including hamlets.
3. Orientation of the traditional healers about the importance of EDPT.
4. Filling up the vacant posts of MPHWS and Laboratory Technicians and MTS.
5. Mapping of insecticide resistance and study on vector bionomics.
6. Use of larvivorous fishes looking to the large numbers of water bodies available.
7. Introducing second line of treatment, where drug resistance foci have emerged.
8. Collaboration with irrigation department to find out solutions for minimizing the mosquitogenic conditions which are caused by irrigation.
9. Treatment of the community owned bed nets.
10. Promoting the use of mosquito nets particularly in the high-risk groups such as pregnant women and children.
11. NGOs working in the district and other sectors will be actively involved for undertaking various activities such as surveillance, treatment of nets etc.
12. The highly endemic villages in various districts will be targeted for intensified surveillance and effective vector control measures.

**GOAL:** To reduce the State API by 20% of current API (5.4).

**Objectives:**

**Objective 1:** Improve access to quality diagnosis and treatment in high risk areas.

**Sub-objectives:**

- Up-gradation of peripheral health facilities and small hospitals in the diagnosis and treatment of severe malaria
- Use of second line Sulpha-Pyrimethamine / Artesunate combination therapy in the drug resistant areas.



- Ensuring availability of combi blister packs and rapid diagnostic kits for all the villages situated in remote and inaccessible areas.

### **Strategies:**

- Establishing quality treatment facilities (a minimum of 20 facilities in each district) for rapid diagnosis and treatment with appropriate anti malarials.
- Training or re-training of existing laboratory technicians in the public, private and voluntary sectors to improve access to diagnosis and improve quality particularly in endemic areas.
- Rapid Diagnostic Test (RDT) will be used in remote inaccessible or forested areas where access to laboratory services is difficult.
- Training of personnel of peripheral health facilities in the public and private sectors for the treatment of severe malaria and supply of anti-malarial drugs.
- Strengthening secondary and tertiary health care facilities for treatment of complicated cases of malaria.
- Capacity building in clinical management of complicated malaria cases at PHC / CHC and district levels by involving tertiary health care institutions in hands on training.
- Inter-sectoral collaboration with public and private sectors to facilitate diagnosis and treatment of malaria.

**Objective 2:** Ensure high quality integrated vector control in endemic areas.

### **Sub-objectives:**

- Community mobilization efforts to promote use of ITNs including treatment of community owned bed nets.
- Promotion of biological control measures using larvivorous fishes through inter-sectoral cooperation and the involvement of various govt. agencies.
- Selective use of IRS considering the susceptibility status of vector mosquitoes to different insecticides.
- Source reduction measures and use of larvicides in urban areas.
- Vector mapping in endemic areas.

### **Strategies:**

- To popularise the use of mosquito nets through community awareness campaigns and advocacy workshops. Supply of mosquito nets to the most vulnerable sections with focus on the endemic areas, drug, resistant pockets and from where deaths have been reported. The insecticide for the treatment of bed nets will be supplied under the project and possibility of the involvement of NGOs will be



explored for mobilization of the community and organization of insecticide treatment camps.

- ii. *Perennial water bodies (breeding places for vectors of malaria and filaria) will be seeded with larvivorous fish, which is an environmental friendly and cost effective vector control measure. The community, NGOs, school children will be actively involved.*
- iii. *Indoor residual spray would be carried out selectively as per the national norms (high API, high SPR, reported death and drug resistance). Synthetic pyrethroid and DDT would be supplied from the project funds.*

**Objective 3:** *Maintain vigilance in non endemic areas through strengthening fever surveillance.*

**Strategies:**

- i. *Establishing fortnightly monitoring of fever incidence by optimally utilizing and re-organizing the existing staff and carrying out pulse malaria campaigns by team mode of work during the transmission season.*
- ii. *Establishment and strengthening of functional FTDs/DDCs and involvement of Asha and ICDS workers in drug distribution.*

**Objective 4:** *Enhance awareness about vector borne diseases control and promote community, NGO and private sector participation.*

**Strategies:**

- i. *Develop and implement strategy for enhancing awareness about various strategies of control of vector borne diseases with particular emphasis on treatment of mosquito nets and biological control through public private partnership.*
- ii. *Encourage local NGOs, PRIs, CBOs, FBOs and SHGs etc. to participate in malaria control through training and sharing of technical guidelines with State & District bodies of IMA / FOGSI / Paediatric Association / Association of Physician of India. These agencies will be encouraged to participate in providing access to treatment, biological control, mosquito net distribution and in the insecticide treatment of community owned mosquito nets.*
- iii. *Organized private sector, large industries etc. will be encouraged to have work-place policy guidelines for control of vector borne diseases including insecticide treatment of community owned mosquito nets among their employees and to ensure access to diagnosis and appropriate treatment of malaria.*
- iv. *Promotion of folk art media (Kala Jatha) by the rates approved by the Information Department.*



- v. Organizing malaria panchayat in every village during the malaria month through Panchayat Raj institutions by involving Panchayat members, Mahila Mandals, NYKS, Youth Club Teachers and other community influencers to discuss the malaria problem in their villages and services available to control it.
- vi. Inter-sectoral collaboration with Tribal Welfare department, Department of Fisheries, Forest Sport and Youth affairs education, Railways etc.

**Objective 5:** Building the institutional and management capacity for improved programme monitoring.

**Sub-objectives:**

- Ensuring availability of qualified staff at different levels
- Building skills of health staff at all levels by training programmes
- Supplies of necessary equipment / material.

**Strategies:**

- i. Coordination cells at state / district levels. State and district vector borne disease control societies will be established / strengthened.
- ii. Ensuring mobility of the staff by providing vehicles / hiring of vehicles.
- iii. Strengthening supervision of the programme by improving the skill of the supervisory staff as well as facilitating their mobility for supervision at district and sub-district level.
- iv. Establishing technical resource groups on management malaria in Government Medical Colleges. The group will be involved in training, supervision and monitoring of the programme in their respective zones.
- v. Strengthening computerized Management Information System (MIS) up to district level.
- vi. State is keen to impart training of Rapid Diagnosis Kit examination to 60,000 Mitamin and 8180 field worker.

**Objective 6:** Promotion of operational research

**Sub-objectives:**

- Community behaviour change studies in respect of use of bed nets, biological control, acceptance of IRS, treatment seeking behaviour.
- Drug resistance studies through Medical Colleges and NIMR
- Vector bionomics, transmission dynamics and insecticide susceptibility studies through NIMR Raipur Unit.
- Evaluation of the efficacy of various interventions viz., IRS, ITMN, biological control.



**Malaria:**

All the ongoing activities under the National Vector Borne Diseases Control Programme as per the guidelines of Government of India will be sustained. More emphasis will be put on Early Diagnosis and prompt/complete treatment in the high risk areas to reduce morbidity and mortality due to malaria for which the deficiencies in the quality of surveillance and laboratory services will be addressed by deploying more Mitanins, providing rapid diagnostic kits and combi blister packs.

Similarly integrated vector management will be attached priority by putting more emphasis on the use of insecticide treated mosquito nets and biological control using larvivorous fish.

**Logistics & Activities**

**A. Indoor Residual spray:** Mapping of insecticide resistance based on available data is regularly done and regarding the susceptibility status of vector mosquitoes to different insecticides can be classified as under.

Insecticide used	Name of the districts
DDT 50 % WDP	Sarguja, Koriya, Jashpur, Bilaspur, Korba, Raigarh, Janjgir, Mahasamund, Kawardha, Rajnandgaon, Dhamtari, Durg, Raipur
Synthetic Pyrethroid	Bastar, Kanker and Dantewada

The following aspects will be given more emphasis during IRS.

- The selection of effective insecticide will be done based on the susceptibility status of malaria vector(s) from the sprayed area.
- Selection of the areas will be based on the national norms (API more than 2, high SPR, reported deaths and drug resistance etc.).
- The focal IRS will be carried out in the villages showing rising trend of malaria cases particularly *P. falciparum* cases.
- The cone bioassays will be carried out at regular intervals with the help of NIMR to determine the bio efficacy of the insecticide used for IRS and assessment of quality and coverage will be ensured by providing feed back to concerned MOPHC/BHO and DMO.



The population projected for IRS and the requirement of insecticides are shown in the following table.

Year	Eligible population in lakhs		Quantity of insecticide required in M.T (2010-11)		Received for the year 2009-10	
	DDT 50% WDP	Synthetic Pyrethroid in terms of 2.5% WP	DDT 50% WDP	Synthetic Pyrethroid in terms of 2.5% WP	DDT 50% WDP	Synthetic Pyrethroid in terms of 2.5% WP
2010-11	56 lakh	30 lakh	900	180	800	0

Currently Synthetic Pyrethroid (Alphacypermethrin 5% WP) is being used in 3 districts as mentioned above.

The spray operation will be commence from 1<sup>st</sup> May 2010 first round and 16<sup>th</sup> July 2010 2<sup>nd</sup> round and training will be given to spray staff from 29<sup>th</sup> April 2010.

**Manpower requirement:** 1590 persons for five months

**Personal Protective Gears:** Personal protective gears including cap, mask, gloves, goggles etc will be provided to the spray staff.

**Availability of Fund:** The staff engaged for indoor residual spray will be paid only daily wages from state budget or in case non availability such fund, than fund may be arrange from VHSC.

**BCC:** Advance notice will be given to all villages, VHSC, and PRI.

**Monitoring and Supervision:** It will be carried out by mapping of vector density and bio efficacy of insecticide towards vector for monitoring the impact of IRS in the PHCs in endemic areas covered under IRS wherever feasible with the help of NIMR. The checklist developed for the supervision will be used for timely corrective measures during the spray operation.

IRS Supervision at various level			
Village level	Blocks / PHC level	District level	State level
MPW (Male) / Female	MO-PHC, Malaria Technical Supervisor (MTS)	CMO/DMO/AMO/VBD Consultants	SPO / State Consultants.



VHSC/ Village chief	PHC Supervision / Malaria Inspector	Senior Inspector	Malaria	Other State Officers
ASHA / Mitani	Block Extension Educator			

## B. Medicine & R.D.Kits

### 1. ACT Combi Pack (Adult):

Requirement in numbers: No. of PF cases X 60% X 1 + 25% Buffer + 40% Exigency.

Total PF cases 79137 X 60% = 47482 x 1 = 47482.

Buffer: 47482 x 25% = 11870

Exigency: 47482 X 40% = 189952

**Total: 2,49,304**

### 2. ACT Combi Pack (Child)

i. 0-1 year : 3956

ii. 1-4 years: 8902

iii. 5-7 years: 12858

iv. 9-14 years: 14837

**Total: 40,553.**

(as per technical norms)

### 3. Primaquine (2.5 mg):

Requirement of Primaquine tablets in numbers: Total no. of P. vivax cases X 30% x 4 x 14) + 25% buffer and 40% for exigency.

Total P. Vivax 21696 \* 30% X 4 X 14 = 364492.

Buffer 25% : 91123

Exigency 40%: 145796.

**Total: 6, 01, 411**

### 4. Primaquine (7.5 mg):

Requirement of Primaquine 7.5 mg tablets in numbers: Total no. of P. Vivax cases X 70% X 2 X 14 + 25% Buffer + 40% exigency.

21696 x (21696 x 70%) = 15187 X 2 X 14 = 425236



Buffer (25%): 106309

Exigency (40%) : 170094

Total: **7,01,639**

### **5. Requirement of Arteether Injection in numbers:**

(No. of PF cases X 60% X 10% X 3 ) + 25% buffer and 40% exigency.

$$79137 \times 60\% = 47482 \times 10\% = 4748 \times 3 = 14244$$

Buffer 25%: 3561

Exigency: 40% = 5697

Total: **23,502**

### **6. Requirement of Quinine Injection in number.**

(No. of PF cases x 40% x 10% x 10) + 25 buffer and 40% for exigency.

$$79137 \times 40\% \times 10\% \times 10 = 31654$$

Buffer:  $31654 \times 25\% = 7913$

Exigency:  $31654 \times 40\% = 12661$

Total : 52,228

### **7. Requirement of Quinine sulphate Tablets in numbers:**

(No. of PF cases x 40% x 10% x 30) = 94964

Buffer 25%:  $94964 \times 25\% = 23741$

Exigency:  $94964 \times 40\% = 37985$

Total: 1,56,690

### **8. Requirement of RD Kits:**

Total R.D.Kits require for 16 districts is 30,00,000.

### **C. Distribution and promotion of use of LLIN**

The state is planning to procure LLIN worth of Rs. 10,00,00,000 for coverage of all households of the Bastar region, this procurement in addition to the 1,00,000 LLIN supply to the District Kanker by Government of India.



**D. Biological Control (Use of Larvivorous fish):** Rapid industrialization, urbanization and development of irrigation projects have played an important role in the creation of mosquitogenic conditions in many parts of the state. Therefore due importance has been given to the promotion of biological control measures using larvivorous fish.

Use of larvae eating fishes for control of mosquito breeding will be promoted on a much larger scale. This will involve establishment and maintenance of hatcheries, at the district, block and PHC levels.

Training to the staff involved will also be imparted and the required equipments for fish transportation. Provision of storage tanks at PHC level has also been proposed under the project.

The community, NGOs, school children will be actively involved in this activity.

In addition to the facilities established in the state for the promotion of this activity it is proposed to utilize all the natural water bodies as hatcheries in all the districts and blocks of the state. Existing hatcheries will be maintained for ensuring the availability of fishes. It is also proposed to provide necessary equipment in all districts for the transport of fish.

#### **E. Strengthening of the Central Lab Malaria:**

Central lab malaria is state unit to look after the quality and cross checking of peripherally examined slides in the field labs. 8.5% negative slides and total positive slides of 2<sup>nd</sup> fortnight of the district are examined and cross checked every month.

The training programme and re-orientation of the technicians / microscopist are also proposed to be organised in future to strengthen the National Malaria Control Programme in the State.

There will be set-up of 35 staff in the Central Lab.

**E. Advocacy to promote community awareness:** Participation of community in various activities under the programme is of utmost importance. Community participation in activities like use of insecticide treated mosquito nets and use of biological control using larvivorous fishes for the control of mosquito breeding will be enhanced by advocacy at the local level. NGOs will be roped in to improve the acceptance of these methods of vector control by the community.

Awareness promotion on other aspects such as EDPT, pregnancy and malaria will also be intensified under the project.

**F. Information Education and communication:** To promote awareness in the community the IEC activities initiated under the EMCP will be sustained further. The IEC strategy will include



other vector borne diseases also. To have an integrated awareness campaign particularly to disseminate messages through all possible media which are effective.

### **BCC / IEC will be developed for awareness generation**

- Organised Health camps, Mela at the tribal and hard to reach areas of the high risk districts.
- Organised sensitization programme and motivate to the CBOs, FBOs NGOs PRI and religious leaders of the communities.
- ORGANISED Workshop and seminar with different stakeholders.
- Use awareness creation through Electronic media and print media.
- Display Hoarding, Flex banner, wall painting, poster, leaflet distribution and slide show.
- Involve to local community based programme and tools for awareness generation to the communities. i.e. Nukkar Natak, Folk media, Cultural programme, Duggi and Munadi.

### **Strategies**

#### **Inter personal Communication**

- i) Man to man or house to house communication done by Mitnin & Health Worker.
- ii) Awareness generation will be done at the villages through KOTUAL by their own system (Munadi).

#### **Mass Communication**

- iii) Awareness generation through religious Networking.
- iv) Malaria prevention, control and resource available will be printed in school booklist and message will percolated by its own system.
- v) Malaria prevention, control and resource available will be printed in Electric Bill and it will be distributed through its own distribution system.

**G. Training of medical and para medical personnel:** Different categories of staff working at different levels will be trained. Integrated training programmes covering vector borne diseases will be organized. Refresher training will be organized for all categories of staff every three years.

The training load in the state for the year 2010-2011 is as under.

Comprehensive Training Planning (CTP) : Annexure-I

### **H. Inter sectoral collaboration/public- private partnership**



*In Chhattisgarh state several initiatives have already been taken for Public- Private Partnership in the Health sector for service delivery particularly where there is deficiency in the general health care services.*

*Under NVBDCP also it is proposed to have fruitful partnerships with field level NGOs to implement various activities for better service delivery and acceptance of the community.*

*Linkages also will be established with various industries, project authorities, mines, forest, railways and other sectors to have better prevention and control of VBD prevention and control services to high-risk population. A state level Task Force has been established under the chairmanship of Health Secretary to have intersectoral collaboration.*

*Fever Treatment Depots (FTDs), Provision of microscopy and treatment centres and Hospital based treatment of severe and complicated malaria cases will be strengthened.*

*Similarly various departments and sectors will be involved for the following interventions for providing services to high-risk population in the vulnerable areas viz., tribal districts, bordering districts.*

- *Early Diagnosis and quality treatment.*
- *Promotion of insecticide treated bed nets, insecticide treatment of community owned bed nets and distribution of insecticide treated bed nets in selected areas*
- *Promoting the use of larvivorous fishes*
- *BCC.*
- *Monitoring and Evaluation*

*Private collaboration will be increased through their active services which are provided for the community people. Initially need to be involved to the Private Pathological lab, Private Nursing home, Quakes and Private Practitioners. Motivate to the private practitioners to open a Malaria clinic at the un served / underserved area.*

### ***I. NGO involvement for Behaviour Change Communication and awareness generation.***

*Identified NGOs will involve to Awareness generation and Behaviour Change Communication to the community after selection by State & Gol.*

### ***J. Management Information System:***

*For effective implementation of the NAMMIS in the state, the first round training has been completed by the all DMOs and VBD consultants. The ongoing training will be continued for the other concerned staff who will newly join in the programme.*



**K. Operational Research.** It is proposed to undertake operational research in all key areas by involving NIMR Field Unit, Raipur and the newly formed Regional Office for Health & FW, GoI and the Medical Colleges of the state.

State and District will motivate to the existing Research Institutions in the State to cooperate and participate to do epidemiological research work for high risk districts.

The proposed operational research activities under the project are as under.

- i. Proposed studies on vector bionomics and transmission dynamics by NIMR Raipur Unit.
- ii. Monitoring of drug resistance in *P. falciparum* by NIMR Raipur Unit, ROH&FW and Medical Colleges.
- iii. Mapping of vector resistance to insecticides to be jointly carried out by NIMR Raipur Unit and Directorate of Health Services.

#### **L. Monitoring and evaluation**

The steps initiated by the state and the activities proposed for better monitoring and evaluation are as under.

To improve programme monitoring at the district level the state has rationalized the workload of district level programme officers by entrusting them with specific responsibilities.

All the national health programmes are integrated with the Primary Health Care Delivery system which has ensured better monitoring of activities.

The monitoring and evaluation mechanisms developed under the EMCP will be further strengthened. The important aspects for monitoring and evaluation under the project are proposed as under.

1. Mapping of resistance in vector mosquitoes to insecticides as well as in malaria parasites (*P. falciparum*) to the chloroquine.
2. Interaction with stake holders by organizing meetings and workshops
3. Frequent field visits
4. Sample surveys to validate information on monitoring indicators of major objectives.
5. Process and performance indicator for each activity will be monitored regularly.
6. Impact indicators will also be set and monitored.
7. Progress of activities will be monitored at quarterly intervals against the set benchmarks.
8. Roles and responsibilities of functionaries at different levels will be defined.
9. Close interaction with NVBDCP and all related institutions functioning in the state will be ensured.



10. Utilization of funds and commodities will be monitored regularly through SOEs and stock position reports.

**M. Inputs required for enhancing the capacity for supervision and monitoring:**

**Computer Systems:** It is proposed to provide computers to all districts.

**Vehicles:** Vehicles will be provided at district level (16) and state level 3 will be required.

**Institutional strengthening:** To equip the district and state level offices as well to meet the expenditure for POL and other contingency expenditure as per proposed budget.

**Human resources:** At the district and state levels, Consultant (4), Computer Operator & Data Analyst (21), Accountant (17) and Driver (20) are required for effective implementation and management of various activities.



### Proposed Budget for NVBDCP for 2010-11

Activity Proposed	Particular/Indicator(s)	Funds required for State	Funds required for District	Total Budget for Approval (lakh)
NVBDCP Activity under NRHM for State/district:-				
DBS				
MPW ( For 9 districts)	@ Rs.6000/-per month for 830 Nos	0	597.60	597.60
VBD Consultants (for 7 non WB District )	@ Rs.30000/- per month for 7 Nos.	0	25.20	25.20
MTSs(for 7 non WB District )	@ Rs.10000/- per month for 42 Nos.	0	50.40	50.40
LTs(for 7 non WB District )	@ Rs. 6000/- per month For 21 Nos.	0	15.12	15.12
Data Entry Operator (for 7 non WB District )	@ Rs. 6500/- pm	0	5.46	5.46
Financial & Logistic Assistant (for 7 non WB District )	@ Rs .8000/- pm	0	6.72	6.72
ASHA( Incentive after complete cure for positive cases)	@ Rs. 20/- per case to ASHA/Mitanin	0	8.00	8.00
NAMMIS(Recurring expenditure on Meeting, MIS Training at State & District and		1	0	1



other cost required like printing of format etc.					
IEC		15.00		5.00	20.00
Training		0.50		2.50	3.00
Central Lab: Renovation & Dev. Work (waste disposal, Two chamber and boundary wall.	Rs. 7.7 lakh.	23.20			23.20
Equipment ( Microscopes, Computer & Fax).	Rs. 14.50 lakh				
Contingency expenditure	Rs. 1.00 lakh				
Procurement of Essential materials, Equipments & Other operational Exp. :- Replacement of Condemn Microscope Lancet Micro slides Laboratory Articles ( Glass ware, lab reagents & consumable etc.) Registers and Forms/Stationery Monitoring & Evaluation(Hire up agency for Base/ Mid /End term evaluation at state and Stationery &Printing/	100Nos.@ Rs.25000 each 1Crore Lancet @1.25each 10 Lakh @ Rs.0.55 each	25.00 125.00 5.50 25.00 10.00	0 0 0 0 0	25.00 125.00 5.50 25.00 10.00	



<b>Monitoring format cost at District</b>				
IRS Pump maint. cost				7.80
Rent for Hiring Store				
Administrative/Office Exp.				3.60
				13.68
				19.20
<b>Sub-Total( DBS)</b>				<b>990.48</b>
<b>Additional support under World Bank for project state/districts :-</b>				
<b>Human Resource -</b>				
At State Level :-				
Coordinator/Consultants				13.20
				0
				13.20



	Consultant @Rs25000/-			
GIS Data Entry	@ Rs. 6500/-pm	0.78	0	0.78
Insect Collector (Two)	@ Rs 8000/-pm	1.92	0	1.92
Accountant	@ Rs.10000/-pm	1.20	0	1.20
Secretarial Assistant	@ Rs. 6500/-pm	0.78	0	0.78
Other Expenditure on HR		0.57	0	0.57
At District Level :-				
VBD Consultants	@ Rs.30000/- pm	0	39.60	39.60
MTSs	@ Rs.10000/- pm	0	79.20	79.20
LTs	@ Rs. 6000/- pm	0	21.60	21.60
Data Entry Operator	@ Rs. 6500/- pm	0	8.58	8.58
Financial & Logistic Assistant	@ Rs .8000/- pm	0	10.56	10.56
Total Human Resource		18.45	159.54	177.99
Capacity Building in project areas-				
Training under head Capacity Building :-				
Medical Specialist at District Hospital	11 batches @Rs.23688	2.61	0	2.61
SSMO	2 batches @Rs.13200	0.27	0	0.27
Medical Officers BMOs	5 batches @Rs.26965	1.35	0	1.35
Medical Officer of PHCs	48batches@Rs.26045	0	12.50	12.50
Laboratory Technicians(induction)	16batches@Rs.33258	5.32	0	5.32
Health Supervisor (M)	19batches@Rs.30112	5.73	0	5.73



Health Supervisor (F)	8 batches @Rs.25910	2.08	0	2.08
Health worker (M)	72batches@Rs 32152	0	23.15	23.15
Health Worker (F)	105batches@Rs31579	0	33.16	33.16
ASHA/Mitanin Training in 2 quarters	600batches @Rs.10000	0	60.00	60.00
Spray Squads Training	32 batches @Rs.2500	0	0.80	0.80
Total Training		17.36	129.61	146.97
IE C under head Capacity Building :-				
Health Camps/Mela	@Rs.2 Lakh for11 District	0	22.00	22.00
IEC Awareness activities BCC & partnership with NGOs/CBOs/PRI/Community	@Rs.1Lakh for 11District	0	11.00	11.00
Flex banners, Wall writing, Poster, Pamphlet & slide show etc.		10.00	0	10.00
Nukkar Natak, Folk media, Cultural Programme, Duggi / Munadi	@Rs.50Lacfor11District	0	5.50	5.50
Electronic Media		10.00	0	10.00
Print Media		10.00	0	10.00
Total IEC		30.00	38.50	68.50
Other Strengthening under head Capacity Building :-				



Printing of NAMMIS Formats & Registers At State Rs.0.30 Lakh & for 11 Nos. districts @ Rs.0.20 Lakh	At State Rs.0.30 Lakh & At District ( 11 Nos) @ Rs.0.20 Lakh each	0.30	2.20	2.50
Infrastructure development cost for State Consultants:- (i)Furnishing of Hall including parturition & installation of AC --Rs.2.52 lakh (ii)Furniture & Fixtures --- 0.18 lakh	i)Furnishing of Hall including parturition & installation of AC --Rs.2.52 lakh (ii)Furniture & Fixtures --- 0.18 lakh	2.70	0	2.70
Infrastructure development cost for undeveloped district setup (not covered in state budget) districts like Dantewada, Jashpur nagar, Koriya ,Korba, Dhamtari , Kawardha, Narayanpur & Bijapur	@ Rs 2.00 Lakh each district for 8 Nos. undeveloped district's setup	0	16.00	16.00
Replacement by back basis of existing Photocopier machine & Fax machine. and One Computer with Printer& UPS @ Rs0.40 Lakh to each and every district, One Fax@ Rs. 0.10 lakh to each and every district (for all 18 Nos. districts)	At State Rs.1.00 Lakh & One Computer with Printer& UPS @ Rs0.40 Lakh to each district, One Fax@ Rs.0.10lac to each district (for all 18Nos.districts)	1.00	9.00	10.00





Telephone/Mobile/Internet/ Postal Exp. & other means of communication , Printing & Stationery and Other Petty Office Exp.	2.60	0	2.60
Total Other Strengthening Cost	6.6	27.20	33.80
Seminar (Inter Sartorial Advocacy) under head Capacity Building	3.00	0	3.00
Meeting & Workshop Exp. under head Capacity Building			
State Consultant & SPO Staff	0.10	0	0.10
CMHO/DMO(Re-orientation)	0.90	0	0.90
VBD Consultant(Re-orientation)	0.10	0	0.10
Contractual MTSS	0.57	0	0.57
Contractual LTs	0.27	0	0.27
Total Seminar & Meeting Exp.	4.94	0	4.94
Total Capacity Building in project areas	58.90	195.31	254.21
Mobility Support			
At State Level :-			
POL, Vehicle Maint., Taxi Freight, TA / DA, Local Conveyance & Hiring of Vehicle (3 Nos)	Vehicle Hire @ Rs.20000/-pm & Other on actual basis	0	14.60
Logistic Supply Chain/ Article Transportation	@Rs0.15 Lakh per month		



(Drugs, Insecticides, Lab material, Equipment & Other Misc. items)			1.80	0	1.80
At District Level :-					
POL, Vehicle Maint., TA/DA, Local Conveyance & Hiring of Vehicle	Vehicle Hire @ Rs.20000/-pm & Other on actual basis			31.20	31.20
Logistic Supply Chain/ Article Transportation (Drugs, Insecticides, Lab material, Equipment & Other Misc. items)	@ Rs.0.10 Lakh per month to all 18 Nos. districts	0		21.60	21.60
Total Mobility Support			16.40	52.80	69.20
SUB Total (World Bank):			93.75	407.65	501.40
Grand Total- Malaria			331.15	1160.73	1491.88

### Budget for Commodities

Sl. No.	Commodities	Quantity and price	Amount
1	Synthetic Parathyroid	180 MT @ 160 / KG	2,88,00,000



			180000 X 160 = 2,88,00,000/-		
2	DDT		900 MT @ 600 / KG. 900000 Kgs X Rs. 600 = 54,00,00,000		54,00,00,000
3	LLIN		10,00,000 LLIN @ 250 per LLIN. 10,00,000 X 250 = 25,00,00,000		25,00,00,000
4	ACT Combipack (Adult)		2,49,304 @ 25/- each pack. 249304 x 25 = 62,32,600		62,32,600
5	ACT Combi Pack (Child)		40553 @ 20/- each pack. 40553 x 20 = 8,11,060		8,11,060
6	Primaquine (2-5 mg)		6,01,411 @ 1.40 each. 6,01,411 x 1.40 = 8,41,975		8,41,975
7	Primaquine (7.5 mg)		7,01,639 @ 1.80 each = 12,62,950		12,62,950
8	Arteether Injection		23,502 @ 11 each Ample = 2,58,522		2,58,522
9	Quinine Injection		52,228 @ 17.34 each = 9,05,633		9,05,633
10	Quinine Sulphate Tabs		1,56,690 @ 3 each = 4,70,070		4,70,070
11	R.D.Kits		30,00,000 @ 15 each = 4,50,00,000		4,50,00,000
TOTAL					874582810.00



### Executive Summary Sheet

#### Fund allocation of NVBDCP in State PIP Chhattisgarh for F.Y.2010-11

Activity Proposed	Allocation of Fund		Total Proposed Budget
	State	District	
NVBDCP Activity under NRHM for State/district(DBS)			
Human Resource like(for non WB districts) MPW, VBD, MTS, LTs, DEOs, F&LA	0	700.50	700.50
ASHA	0	8.00	8.00
NAMMIS	1.00	0	1.00
IEC	15.00	5.00	20.00
Training	0.50	2.50	3.00
Central Lab	23.20		23.20
Procurement of essential material, equipment & other operational Exp.	197.7	37.08	234.78
Sub Total (DBS)	237.4	753.08	990.48
Additional Support under World Bank for Project State/District			
Human Resource(for WB districts)GIS-DE, IC, Acct., SA, VBD, MTSS, LTs, DEOs, F&LA	18.45	159.54	177.99
Capacity Building in project area Training+ IEC+ Strengthening cost +Seminar + Meeting & workshop	58.90	195.31	254.21
Mobility Support	16.40	52.80	69.20
Sub Total (World Bank Supported)	93.75	407.65	501.4
Grand Total Malaria (DBS+WBS)	331.15	1160.73	1491.88
Budget for Commodities			8745.82
Grand Total Including Commodities			10237.7

### Filarial Programme

Filariasis has been a major public health problem in India next only to malaria. The prevention of disability due to lymphatic filariasis (LF) is a component of the Global Programme to Eliminate Lymphatic Filariasis (GPELF).

The aim is to contribute to the prevention of suffering and disability due to LF by training health and non-health workers (e.g., social workers, teachers, religious leaders) at the district level, who in turn will train others how to teach the principles of home-based self-



care to LF sufferers and their relatives in order to prevent the chronic consequences of the disease.

### Mass Drug Administration December 2008

Sl. No.	Name of District	Population	Eligible Population	Population Covered	%
1	Raipur	3585436	3098490	2966173	95.73
2	Durg	3233342	2626674	2275345	86.62
3	Dhamtari	784460	703812	679802	96.59
4	Mahasamund	1047952	915891	891221	97.31
5	Bilaspur	2304057	2268797	1840076	81.10
6	Janjgir	1543939	1412882	1320080	93.43
7	Jashpur	844276	749986	739622	98.62
8	Raigarh	1390327	1230131	1156598	94.02
9	Ambikapur/ Sarguja	2365956	1865499	1828762	98.03
TOTAL		17099745	14872162	13697679	
Average of %					92.10

### Mass Drug Administration (MDA) Comparative Statement 2007 and 2008

Sl. No.	Name of District	Year	Population	Eligible Population	Population Covered	%
1	Raipur	2008	3585436	3098490	2966173	95.73
		2007	3569947	3061203	3052258	99.71
2	Durg	2008	3233342	2626674	2275345	86.62
		2007	3283341	2000000	1919414	95.97
3	Dhamtari	2008	784460	703812	679802	96.59
		2007	866668	799110	711504	89.04
4	Mahasamund	2008	1047952	915891	891221	97.31



		2007	1029708	896306	873221	97.42
5	Bilaspur	2008	2304057	2268797	1840076	81.10
		2007	2403427	2268797	2068037	91.15
6	Janjgir	2008	1543939	1412882	1320080	93.43
		2007	1501153	1313602	1244645	94.75
7	Jashpur	2008	844276	749986	739622	98.62
		2007	828524	748507	607981	81.23
8	Raigarh	2008	1390327	1230131	1156598	94.02
		2007	1478784	1266186	1080344	85.32
9	Ambikapur/ Sarguja	2008	2365956	1865499	1828762	98.03
		2007	2375608	1191681	1064719	89.35
TOTAL		2008	17099745	14872162	13697679	
		2007	17337160	13545392	12622123	
Average of %		2008				92.10
		2007				93.18

**Goal:** To Eliminate Lymphatic Filariasis (ELF) from India by the year 2015.

#### Objectives:

- To reduce and eliminate transmission of LF by Mass Drug Administration (MDA) of Diethylcarbamazone Citrate (DEC).
- To reduce and prevent morbidity in effected persons.
- To strengthen to existing health care services.

The goal and objectives will be achieved through the existing health services with improved health care delivery system and enhanced activities by involving the NGOs, private and public sector. IEC for integrated vector borne disease control approach will be implemented through intra and intersectoral cooperation and coordination.

#### Strategies:

- Single day mass therapy with DEC at a dose @ 6mg/kg body weight annually adjusted to different age groups.
- Management of acute and chronic filariasis and self-care methods.
- IEC for inculcating individual / community based protective and preventive measures for filarial control.

#### Requirement of DEC & Albendazole

**Eligible population 15243966**

**DEC:**  $\text{Total population} \times 2.5$

$$15243966 \times 2.5 = 3,81,09,915 \text{ Tablets.}$$



**Albendazole:**

Total population x 1

$$15243966 \times 1 = 1,52,43,966 \text{ Tablets}$$

**Proposed activities for Lymphatic Filariasis elimination:**

**MDA for LFE and morbidity management continue for 2 more years.**

**Morbidity management of Lymphnt:** MDA will be taken up in all the nine endemic districts annually for 5 years by ensuring 85% coverage to bring down MF rate less than 1%.

Assessment survey will be carried out after 5 years in children and if a single case is found positive MDA will oedema cases and hydrocelectomy camps for disability prevention and personal protection measures to prevent man mosquito contact will also be taken up simultaneously.

**A. Planning and preparatory activities for ELF:** As per the guidelines of Government of India the state has plan and implement various activities related to ELF. During the preparatory stage the following activities have to implemented form the state and district level.

- Meeting of district level officers to plan about MDA and other activities related with ELF.
- Line listing for eligible population of affected districts.
- Meeting of the District level coordination committee (three meetings prior to MDA).
- Organizing press meet/media flash.
- IEC activity by the MOPHCs and para medical staff.
- Advocacy workshops.

**B. Training and capacity building of different tiers of health personnel:** Through this activity has been commenced since 2004, reorientation training will be organized to sensitize them about MDA, morbidity management, and mapping of Lymph oedema cases.

The training programmes will be organized through the District Training teams.

**C. Surveys to estimate filaria endemicity:** Though mapping of a major portion of Filariasis cases has been completed in 9 districts, this activity will be further enhanced to find out each and every filariasis case in other districts as well.

**D. Drug delivery component for DEC, MDA:** The MDA will be carried out through the PHC staff with the support of various health functionaries, NGOs, and personnel from various state departments. DEC will be procured and supplied by the Govt. of India.

Detailed activity plan for each PHC will be prepared for the MDA including the IEC activities and the door to door campaign that is required for its success



**E. Information Education and communication strategies:** All the activities related with ELF require a strong IEC support and therefore various IEC activities are planned to promote the awareness. IEC materials for inter personal communication and display will be prepared and distributed. Print and electronic media will also be used in a big way to disseminate the messages.

**Monitoring and evaluation:** The evaluation of the drug compliance will be carried by the districts. The PSM Departments of Medical colleges will also be involved for this activity. An amount of Rs. 2.35 lakhs is proposed for this purpose.

#### **IV. Implementation arrangements**

##### **1. Monitoring and evaluation**

The steps initiated by the state and the activities proposed for better monitoring and evaluation are as under :

- To improve programme monitoring at the district level the state has rationalized the workload of district level programme officers by entrusting them with specific responsibilities.
- All the national health programmes are integrated with the Primary Health Care Delivery system which has ensured better monitoring of activities.
- The monitoring and evaluation mechanisms developed under the EMCP will be further strengthened.

The important aspects for monitoring and evaluation under the project are proposed as under.

11. Mapping of resistance in vector mosquitoes to insecticides as well as in malaria parasites (*P. falciparum*) to the chloroquine.
12. Interaction with stake holders by organizing meetings and workshops
13. Frequent field visits
14. Sample surveys to validate information on monitoring indicators of major objectives.
15. Process and performance indicator for each activity will be monitored regularly.
16. Impact indicators will also be set and monitored.
17. Progress of activities will be monitored at quarterly intervals against the set benchmarks.
18. Roles and responsibilities of functionaries at different levels will be defined.
19. Close interaction with NVBDCP and all related institutions functioning in the state will be ensured.
20. Utilization of funds and commodities will be monitored regularly through SOEs and stock position reports.



## 2. Inputs required for enhancing the capacity for supervision and monitoring:

- **Computer Systems:** It is proposed to provide New Computers to all districts.
- **Institutional strengthening:** To equip the district and state level offices as well to meet the expenditure for POL and other contingencies.
- **Human resources:** At the district and state levels, Consultant (4), Computer Operator & Data Analyst (21), Accountant (17) and Driver (20) are required for effective implementation and management of various activities.

### Domestic Budget Support of NVBDCP

#### Filaria elimination programme (Chhattisgarh)

S. no.	Component	Details of Fund requirement	Total Budget
1	Planning and preparatory meetings for ELF		
1.1	State level meeting of District level officers.	One-day State level meeting of District officers.	10000
1.2	State level TAC meeting		10000
1.3	Meeting of district level co-ordination committee(DCC) and press meeting followed by meeting of district officials, NGO etc.	Meeting of 9 district level co-ordination committee(DCC) and press meeting followed by meeting of district officials, NGO etc	45000
1.4	Second meeting of DCC and press meet	Second meeting of 9 DCC and press meet	45000
1.5	Third meeting of DCC and press meet	Third meeting of 9 DCC and press meet	45000
1.6	2 TAC meeting at District Level		45000
			200000
2	Training and capacity Building for different tiers of Health Personnel		
2.1	Training for Medical Officer posted at DH&DMO (TOT)	2batches@Rs13200eachbatch	26400
2.2	Training for Ayush Doctors /RMA	9 batches in district @Rs.20146 each batch	181314
2.3	Training For Medical Officer posted at PHC level	12 batches in district @Rs.22112 each batch	265344
2.4	Training for District Para Medical Staff	18 batches in district @Rs.22768 each batch	409824
2.5	Training for District Drug Distributor	629 batches in district @Rs.3000 each batch	1887000



			2769882
3	<i>Mapping to estimate filarial endemic</i>		
3.1	<i>Operational cost for morbidity management</i>	<i>Operational cost for morbidity management</i>	450000
3.2	<i>Material for Night Blood Survey</i>	<i>Rs. 50000 per district Material for Night Blood survey</i>	450000
			900000
4	<i>Drug delivery component for DEC MDA</i>		
4.1	<i>Contingency expenses for drug delivery of DEC</i>	<i>15693965 population @ 20 paisa per head in 9 districts</i>	4000000
4.4	<i>Subsidy for transportation to cover POL Exp.</i>	<i>9 Districts</i>	720000
			4720000
5	<i>IEC</i>		
5.1	<i>IEC activities in 9 endemic districts of state</i>	<i>@ Rs. 1.5 Lakhs per district</i>	1350000
5.2	<i>Printing of IEC Material, enumeration registers, and reporting formats</i>	<i>@ Rs. 1.00 Lakhs per district*9</i>	900000
5.3	<i>Dissemination of messages through news papers, TV and Radio etc.</i>	<i>@ Rs. 50000 per district*9</i>	450000
			2700000
6	<i>Monitoring &amp; Independent evaluation</i>		
6.1	<i>Monitoring and assessment by the states</i>	<i>1 per district per year @ Rs.20,000/-</i>	450000
6.2	<i>Independent evaluation by the centre</i>	<i>1 per State for the year @ Rs. 75000/-</i>	75000
			525000
7	<i>Hydrocoele Operation</i>		
7.1	<i>Comps for Hydrocoele operations</i>	<i>@ Rs. 1.00 Lakhs per district*9</i>	900000
	<i>Grand TOTAL Filaria</i>		12714882



**Comprehensive Training Plan 2009-10 National Vector Borne Disease Control Programme, DHS, Raipur, Chhattisgarh**

S. No.	Target Category	Training Load		Duration in Days		Number of Batches	Schedule (Batch wise)		Budget in INR		Source	Additional Information If Any	Venue	Responsibility of Execution (Dept./ Officer etc.)
		Batch Size	Total	Per Batch	Total		Batch No.	Date (From - To)	Per Batch	Total				
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)
A	As supported by World Bank for Malaria Programme													
1	Training on NVBDCP for Medical Officers.													
1.1	Medical Specialist District Level	25	273	2	22	11	Batch 1 to 11	Jan-10	23688	260568	World Bank	DA trainee@ 120/- and Hono. Trainers @ 1000/-	Medical College in Endemic areas	Training organised by Medical College and Training monitor by SPO and his team at various level.
1.2	SSMO	9	18	2	4	2	Batch 1 to 2	Jan-10	13200	26400	World Bank	DA trainee@ 120/- and Hono. Trainers @ 1000/-	State level by SIHFW	Training organised by SIHFW and Training monitor by SPO and his team at



																	various level.
1.3	Medical Officers BMOs	30	150	2		10	5	Batch 1 to 5	Jan-10	26965	134825	World Bank	DA trainee@ 120/- and Hono. Trainers @ 1000/-	State level by SIHFW	Training organised by SIHFW and Training monitor by SPO and his team at various level.		
1.4	Medical Officer of PHCs	30	1435	2		96	48	Batch 1 to 48	Jan, Feb & March 2010	26045	1250160	World Bank	DA trainee@ 120/- and Hono. Trainers @ 600/-	District level By SIHFW	Training organised by SIHFW and Training monitor by SPO and his team at various level.		
2	Training for paramedical and other on NVBDCP																
2.1	Lab Technician (LTs)	25	378	5		80	16	Batch 1 to 16	Jan , Feb & Mar- 2010	33258	532128	World Bank	DA trainee@ 72/- and Hono. Trainers @ 1000/-	State level by ICMR / ROH&FW Lab.	Training organised by ICMR/ROH&FW Lab. and Training monitor by SPO and his team at various level.		



2.2	Health Supervisor (M)	38	722	2	38	19	Batch 1 to 19	Jan. & Feb. 2010	30112	572128	World Bank	DA trainee @ 72/- and Hono. Trainers @ 1000/-	State level by Central RLTRI	Training organised by Central RLTRI and Training monitor by SPO and his team at various level.
2.3	Health Supervisor (F)	31	249	2	16	8	Batch 1 to 8	Jan-10	25910	207280	World Bank	DA trainee @ 72/- and Hono. Trainers @ 1000/-	State level by Central RLTRI	Training organised by Central RLTRI and Training monitor by SPO and his team at various level.
3	Training for Health Worker on NVBDCP.													
3.1	Health Worker Male	45	3242	2	144	72	Batch 1 to 72	Jan, Feb & March-10	32152	2314944	World Bank	DA trainee @ 48/- and Hono. Trainers @ 600/-	District level by SIHFW	Training organised by SIHFW and Training monitor by SPO and his team at various level.
3.2	Health worker Female	44	4618	2	210	105	Batch 1 to 105	Jan, Feb & March-	31579	3315795	World Bank	DA trainee @ 48/- and Hono.	District level By SIHFW	Training organised by SIHFW and Training



									10										Trainers @ 600/-		monitor by SPO and his team at various level.
4	Training for Mitandin / ASHA	100	60000	1	600	600	600	Batch: 1 x 5 x 120= 600	Jan, Feb & March 2010	10000	60000000	World Bank	Each Mitandin training cost @ 100/-	District level by SHRC	Training organised by SHRC and Training monitor by SPO and his team at various level.						
5	Training for Spray Squad	25	800	1	32	32	32	Batch 1 to 32	Jun-10	2500	80000	World Bank	2 persons from each squads for training @ 100/-	District level By DMOs	Training organised by DMOs and Training monitor by SPO and his team at various level.						
SEGMENT SUB TOTAL (A)		71885			1252			918			14694228										



S. No.	Target Category	Training Load		Duration in Days		Number of Batches	Schedule (Batch wise)		Budget in INR		Source	Additional Information If Any	Venue	Responsibility of Execution (Dept./Office etc.)
		Batch Size	Total	Per Batch	Total		Batch No.	Date (From-To)	Per Batch	Total				
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)
B	As supported under NRHM for Filaria Elimination Programme													
1	Training for Medical Officer posted at D H & D M O (TOT)	9	18	2	4	1	Batch 1 To 2	Jan-10	13200	26400	DBS	DA trainee @ 120/- and Hono. Trainers @ 1000/-	State level by SIHFW	Training organised by SIHFW and Training monitor by SPO and his team at various level / faculty



2	Training for Ayush Doctors / RMA	21	189	2	18	9	Batc h 1 to 9	Jan-10	2014 6	181314	DBS	DA trainee@ 120/- and Hono. Trainers @ 600/-	Distric t level by DMOs	Training organised by DMOs and Training monitor by SPO and his team at various level /faculty.
3	Training for Medical officer posted at PHC level	24	288	2	24	12	Batc h 1 to 12	Jan.& Feb.201 0	2211 2	265344	DBS	DA trainee@ 120/- and Hono. Trainers @ 600/-	Distric t level by DMOs	Training organised by DMOs and Training monitor by SPO and his team at various level /faculty.
4	Training for District Para Medical	25	450	2	36	18	Batc h 1 to 18	Jan.& Feb.201 0	2276 8	409824	DBS	DA trainee@ 72/- and Hono. Trainers @	Distric t level by DMOs	Training organised by DMOs and Training monitor by



	Staff																		SPO and his team at various level /faculty
5	Training for District Drug Distributors	30	5490	2	366	183	Batches 1 to 183	Jan , Feb & March -2010	3000	549000	DBS	Each District Drug Distributors training @ 100/-	District level by DMOs	Training organised by DMOs and Training monitor by SPO and his team at various level /faculty					
SEGMENT SUB TOTAL (B)		6435										448	224	1431882					



# G. NLEP

## G. National Leprosy Elimination Programme

### G.1 SITUATIONAL ANALYSIS

Presently there are 6181 cases under treatment with Prevalence rate (PR) of 2.61 per 10,000 populations as on October 2009 with 4339 new leprosy cases detected since April to October 09.

The national Prevalence rate is 0.79 per 10,000 population with ANCDR 11.40 per 1,00,000 population as at Dec. 2008

#### Situational Analysis with epidemiological Parameters

#### Comparison of Epidemiological Situation of Chhattisgarh with National Figures

Indicators	India (Dec. 08)	Chhattisgarh (Mar'09)	Oct'09
PR/10,000	0.79 (92791)	2.34	2.61
ANCDR/1,00,000	11.40 (102602)	34.21	21.16
MB%	47.76	52.79	52.36
Child %	10.23	7.39	7.81
Female %	35.30	36.25	36.62
Gr. I deformity %	4.39	-	-
Gr. II deformity%	2.72	4.33	4.56

#### Trend of Epidemiological Indicators from 2002-03 to October 2009

	02-03	03-04	04-05	05-06	06-07	07-08	08-09	Oct'09
PR	7.20	6.01	3.60	2.00	1.46	2.39	2.34	2.61
ANCDR	85.9	71.6	59.0	40.0	26.3	36.4	34.21	21.16
PD Ratio	0.83	0.83	0.61	0.50	0.55	0.65	-	-
MB %	40.7	44.73	47.44	50.69	52.23	49.91	52.79	52.36
Child %	11.27	9.09	9.02	6.70	6.19	6.66	7.39	7.81
SC Rate	95.6	97.3	84.8	52.1	26.4	43.2	-	-
ST Rate	103.5	37.7	29.0	20.3	12.9	20.9	-	-



Female %	34.7	32.00	33.36	30.64	31.34	33.10	36.25	36.62
Gr II Disability Rate	2.65	2.07	2.49	2.32	2.82	3.51	4.33	4.56

### **Salient features of Trend of New Case Detection in State, Districts & Blocks**

- New case detection has increased from 7784 in 2007-08 to 7984 in 2008-09
- 6 districts with ANCDR > 20 per lakh, of these 3 districts with > 50 viz. Mahasamund (94.5), Raigarh (61.9) and Raipur (52.6)
- 6 Districts reporting >500 new cases – Raipur (1327), Mahasamund (617), Raigarh (757), Durg (606), Bilaspur (622) & Janjgir (761)
- Out of 146 blocks, 73 blocks (50%) with ANCDR > 20 in 11 districts and 21 blocks with ANCDR > 50 in 5 districts. State 's ANCDR is 35.4 which 3 times higher than country' ANCDR which is 12
- 17 blocks reporting >100 new cases, mostly in Korba(3), Mahasamund (4), Raigarh (3) and Raipur (7)
- 4 urban areas (out of 9) have ANCDR >50 per lakh.

There are 18 districts in the state with operational health care reporting system in 16. Out of 16 reporting districts only 4 (Sarguja, Kanker, Koriya & Dantewada) have achieved the primary goal of Elimination as a public health problem i.e. Prevalence Rate of <1 per 10,000 population, while 5 districts are high endemic with Prevalence rate of more than 2.5 /10,000 namely Mahasamund, Raipur, Raigarh, Bilaspur & Janjgir, as on October 2009.

Mahasamund (57.82) and Raigarh (39.52) are the two districts with highest New case detection rate higher than state's average ANCDR of 21.16 per 100000 populations.

### **Reconstructive Surgery**

- 1 Govt. & 2 NGOs conducting RCS operations
- 137 RCS were conducted by the state in 2008-09

### **Total number of Grade II deformity load since 2001**

2001 – 2007	2767
2007 – 2008	274
2008 – 2009	339
October 2009	229
TOTAL	3609

### **Reconstructive Surgeries conducted since 2001 to Oct. 2009**



<b>Institutions</b>	<b>2001 -2007</b>	<b>2007 -2008</b>	<b>2008 -09</b>	<b>October'09</b>
RLTRI, Raipur	404	109	38	
TLM, Champa	100	19		
TLM, Baitalpur	153		52	
Raigarh	-	-	37	
Kanker	-	-	10	
<b>Total</b>	<b>657</b>	<b>128</b>	<b>137</b>	<b>73</b>

#### **Analysis of BLAC (BLOCK LEPROSY AWARENESS CAMPAIGN) since 2004**

- Four BLAC were conducted in the state
- 63 blocks were identified with PR > 5 per 10,000 in 2004
- 12 blocks taken for analysis
- None of the blocks achieved elimination level till March'08
- As per block information, out of 44 blocks taken for BLAC IV, more than 51 % villages are endemic where new cases have been detected during any time since last three years considering lower range of incubation period to be 3 years.

	<b>No. of blocks covered under BLAC taken for analysis</b>					<b>Blocks achieved elimination on March'08</b>	
	<i>I</i>	<i>II</i>	<i>III</i>	<i>IV</i>	<i>All four</i>	<i>No.</i>	<i>%</i>
India	158	73	35	29	18	64	40.5
Chhattisgarh	12	9	8	4	3	0	0

#### **New Cases Detected in a campaign mode- BLAC – IV**

#### **(BLOCK LEPROSY AWARENESS CAMPAIGN)- SEPT TO JAN.08**

<b>S. No</b>	<b>District</b>	<b>No. of Blocks Covered</b>	<b>Endemic villages/ Total villages (% of endemicity)</b>	<b>Total no. of new cases detected</b>
1	Bastar	3/14	141/308 (45 %)	23
2	Bilaspur	9/10	736/1492 (49 %)	62
3	Durg	2/12	135/263 (51 %)	47
4	Janjgir	1/9	41/72 (57 %)	22



5	Jashpur	1/9	41/110	(37 %)	34
6	Kawardha	¼	74/181	(41 %)	19
7	Korba	2/5	122/296	(41 %)	122
8	Mahasamund	5/5	622/1088	(57 %)	247
9	Raigarh	6/9	554/947	(59 %)	200
10	Raipur	13/15	921/2319	(40 %)	172
11	Total	43/146 (29.45%)	3387/6636 (51 %)		948 (12 %) of total New Cases Detected in year 2007-08

#### **Constraints:-**

Non existence of district nucleus (one district leprosy officer=full/part time, one medical officer, two para medical staff) in the state set up which is severely hampering the implementation of the programme thereby effective supervision & monitoring.

#### **BACKGROUND: -**

In majority of districts the functional district nucleus is not in place and field staff has been nominated as district nucleus for name sake. This kind of arrangement poses the problem as training is imparted to designated staff but this human resource is unable to discharge their duties due to their non availability from their place of posting.

- NON UTILIZATION OF TRAINED PHYSIO THERAPY TECHNICIAN IN THE PROGRAMME.
- HUMAN RESOURCE DEFICIENCY AT ALL LEVELS.

#### **Goal:**

- To further reduce leprosy burden and finally achieve Leprosy Eradication.
- To reduce social stigma & discrimination
- To provide rehabilitative services to all Leprosy affected persons.

#### **Objectives:**

- To further reduce leprosy burden by increase in suspect referral through the existing system of health care delivery (Mitansins & Multipurpose workers)

Background: - At present less than 10 % of new leprosy cases are being referred through the General Health Care staff & 140 referred by MITANINS.

Expected to increase suspect referrals to 25 % by GHCS & 30 % by MITANINS



- **To further reduce leprosy burden by increase in case detection of hidden cases and hence breaking the chain of transmission by curing all the detected cases.**

**Background:** - New case detection rate is the main indicator of the NLEP programme to monitor & study the epidemiological situation in any geographical area. In a well run programme, the ANCDR should gradually decline as the transmission in the area is checked through early diagnosis & prompt treatment of all the leprosy patients.

But in state like Chhattisgarh where deficiency of human resource affecting the service delivery & other operational factors, the ANCDR is expected to increase during this year with the implementation of ASHA incentive scheme in detecting the hidden cases.

At present approximately 8000 new leprosy cases are being detected annually.

Expected to increase 20% of last year's figures through implementation of ASHA Incentive Scheme (Rs 300/- & Rs 500/- incentive is to be given to ASHA on referral of PB & MB cases respectively).

- **Treatment Completion Rate :-** treatment completion or cure rate (proxy indicator) to increase to 100 from the current level of 92.23% (reporting period 2007-08)[PB 94.01% & MB 91.11% and in urban area PB85.69% & MB 78.48%]. Who so ever is put on MDT should complete the treatment in prescribed time period and it is expected that 100 % treatment completion should be one of the main objectives of the programme.
- **Proportion of MB among new cases increases while absolute number decreases in the state, indicating the reduction in transmission & hidden cases being detected at this juncture of the programme.**

**Background :-** At present MB proportion among new leprosy cases has increased from 40 % in 2002-03 to 53 % in 2009, where as the number have come down from 7000 to less than 2627 respectively during the same period.

MB proportion among new cases is expected to increase to 55 % with further reduction in number of infectious cases in the community indicating the reduction in transmission.

- **Reduction in Child proportion among new cases: - it is expected to have further reduction of disease in children.**

**Background :-** At present Child proportion among new leprosy cases has decreased from 11.2 % in 2002-03 to 7.81% in 2009, where as the numbers have also come down from 1000 to less than 392 during the same period respectively.

### **Strategies:**

- **TRAINING OF ALL CATEGORY OF HEALTH SATFF INCLUDING MEDICAL OFFICERS.**



- INVOLVEMENT OF MITANIN IN THE NLEP.
- INTENSIVE IEC/IPC ACTIVITIES.
- INTERSECTORAL CO-ORDINATION.
- PRI INVOLVEMENT
- CO-ORDINATION WITH ALL THE FUNCTIONALITIES OF NRHM.

#### **Activities:**

- On the job capacity building by the District Nucleus team & re-orientation trainings of Medical Officers and general health care staff.
- Half day NLEP sensitization training of District Resource Persons & Mitanins for suspect referral, complication identification, DPMR services & referral.
- Health Mela, IPC meetings in Gram Panchayats, school IEC etc. throughout the year.
- Workshop of Chairman Zila Parishad and other PRI stakeholders.
- Quarterly Review meetings of state Rehabilitation committee under Social Justice & Empowerment, meetings with NGOs etc.
- Meeting of Village Health & Sanitation Committee, Village health nutrition day, review meetings of District programme managers.

#### **Monitoring and evaluation**

- MONITORING & SUPERVISION THROUGH REGULAR FIELD VISITS BY STATE & DISTRICT LEVEL OFFICERS
- QUARTERLY REVIEW MEETINGS
- STATE & DISTRICT NLEP CO-ORDINATION MEETINGS

#### **Activities:-**

- Monthly tour programmes of state & district officials.
- Internal Evaluation of NLEP through state team.
- Quarterly review meetings of district leprosy officers & monthly NLEP co-ordination meetings under chairmanship of CMHO.
- District officers attending monthly meeting of Block & Saturday sector meeting and Monday supervisors 'meeting.



## Budget Proposal for 2010-11

S. No..	Activity Proposed	Balance as 01.04.09	2009-10			2010-11		
			Amount approved for 09-10	Expenditure till Nov'09	Expected expenditure by Mar'10	Balance as on 1/4/10	Budget proposal for 10-11	Actual Requirement 10-11
			(1)	(2)	(3)	(4) (1-(2+3))	(5)	(6) (5-4)
1	<b>Contractual Services</b> State – SMO, BFO cum AO, DEO, Administrative Assistant, Driver District – Drivers	4.24	10.86	6.49	1.97	2.40	19.51	17.11
2	<b>Services through ASHA/ USHA</b> Honorarium to ASHA, sensitization of ASHA	4.90	15	0.71	5.00	9.29	32.00	22.71
3	<b>Drugs, Material &amp; Supplies</b> Supportive drugs, Lab, Reagents & equipment and printing forms.	-	9.36	0.00	7.00	2.36	9.36	7.00
4	<b>POL/ Vehicle operation &amp; hiring</b> 2 vehicles at state level & 1 vehicle at district	6.81	15.2	5.56	8.00	1.64	19.70	18.06



	level											
5	<b>Behavioural Change Communication (IEC)</b> Quiz, Folk show, IPC workshop, Meeting of opinion leaders, Health melas. Wall painting, Rallies, Hoardings etc.	(-)	1.58	25	2.89	15.00	7.11	50.00	42.89			
6	<b>Training &amp; Capacity Building</b> 4 days training of newly appointed MOs & RMAs (rural & urban) 3 days training of newly appointed health worker & health supervisor 2 days refresher training of MO 5 days training of newly appointed Lab Technician Study material for trainees		8.54	20	7.51	10.00	2.49	37.12	34.63			
7	<b>DPMR</b> MCR footwear, Aids and appliances, Welfare allowance to BPL patients for RCS, Support to Govt. institutions for RCS	(-)	3.50	19.15	6.11	12.00	1.04	22.65	21.61			



8	Urban Leprosy Control	(-)	8.41	7.00	0.27	3.00	3.73	9.24	5.51
9	Supervision, Monitoring & Review		0.10	1.50	0.60	0.90	0.00	8.12	8.12
	Review meetings and travel expenses								
10	Office expenses & Consumables		1.30	6.72	1.98	3.00	1.74	7.26	5.52
11	NGO – SET Scheme		5.00	10.00	0.00	0.00	10.00	-	-
12	Cash assistance		0.43	20.00	2.07	15.00	2.93	20.00	17.07
TOTAL			17.83	159.79	34.19	80.87	44.73	234.96	190.23
	Funds Position								
	Funds received in 2009-10	i)	Rs.	76.00	lakh	2nd instalment of 08-09			
		ii)	Rs.	47.50	lakh	1st instalment of 09-10			
	Total		Rs.	123.50	lakh				
	Loan repaid to NRHM availed in March 2009	(-)	Rs.	37.00	lakh				
			Rs.	86.50	lakh				
	Expenditure from April 09 to Nov. '09	(-)	Rs.	34.19	lakh				



Funds available as on date		Rs.	52.31	lakh				
<b>Note :</b>								
i)	Post of State Medical Officer is vacant							
ii)	Sensitization of ASHA (Mitani) and various Capacity Building (training) programmes are in progress in districts and have been planned to cover to a large extent by Mar'10							
iii)	Behavioural change communication (IEC) activities are in progress in districts							
iv)	Procurement of MCR footwear, supportive drugs and printing of various forms and register is being initiated.							
v)	Out of Cash Assistance it is proposed to purchase 4 vehicles for districts.							
vi)	The GOI NGO-SET Scheme is not found to be applicable in the state in view of one of the conditions of the scheme, which is -							
	allotment of the areas should be made based on the criteria of (a) Urban and per - urban slum areas that are not covered by the regular health system (b) Remote hilly and/ tribal areas, areas separated by geographical barriers and © Leprosy is a problem in those area as evidenced by continued high and static prevalence. Mere non availability of health services in an area should not be considered for addition NGO support.							



## Annexure – 1: Component and Item-wise Cost for 2010-11

### GOI Support

S. No.	Component	Item	Cost (lakh)
1	Contractual Services (Table-1)	Staff for State Leprosy Unit/ Cell	7.85
		Staff for District Leprosy Unit/ Cell	11.66
2	Services through ASHA (Table-2)	ASHA incentive	32.00
3	Drugs, Material & Supplies (Table-3)	Supportive Medicine, Laboratory reagents & equipments and printing of forms etc.	9.36
4	POL/ Maintenance (Table-4)	POL & Vehicle maintenance	19.70
5	IEC (Table-5)	State & Peripheral level	50.00
6	Training (Table-6)	Training 4 days (Rural & Urban)	9.56
		Re-orientation for MO – 2 days	9.52
		Training Staff 3 days	14.01
		Lab Technician – 5 days	1.21
		Study Materials	2.82
7	Disability Prevention & Medical Rehabilitation – DPMR (Table-7)	MCR footwear, Aids and appliances	7.65
		Patient Welfare & support to Govt. Hospitals	15.00
8	Urban Leprosy Control Programme (Table-8)	Townships	6.84
	(Township & Medium cities)	Medium cities - I	2.40
9	Supervision, Monitoring & Review (Table : 9-10)	Review meeting	4.92
		Travel expenses	3.20
10	Office Expenditure & Consumables (Table : 11-12)	Office expenditure	4.06
		Consumables	3.20
11	Cash Assistance (Table : 13)		20.00
	<b>TOTAL</b>		<b>234.96</b>



## Contractual Services

Table – 1

S. No.	Item	No.	Consolidated salary per month in Rs.	Cost (lakh)
1	SLS Surveillance Medical Officer	1	24000	2.88
2	Budget & Finance Officer cum Administrative Officer	1	18000	2.16
3	Administrative Assistant`	1	8400	10.08
4	Data Entry Operator	1	9600	11.52
5	Drivers	1	5400	6.48
	<b>Sub Total</b>	<b>5</b>	<b>-</b>	<b>7.85</b>
1	DLS Drivers	18	5400	11.66
	<b>Total</b>	<b>23</b>		<b>19.51</b>

## Services through ASHA (MITANIN)

Table – 2

S. No.	Item	Unit	Rate per unit	Cost (Lakh)
1	Performance based incentive to MITANIN for case detection (in the year 2008-09, 7900 new cases were detected out of which 52% were MB & 48% were PB. This year 8000 cases are expected to be detected.)	MB 4000 PB 4000	Rs. 500/- each Rs. 300/- each	20.00 12.00
<b>Total</b>				<b>32.00</b>

## Drugs, Material & Supplies.

Table – 3

S. No.	Item	District	Cost per District	Cost (lakh)
1	Supportive Drugs	18	25000	4.50



2	Laboratory reagents & Equipments	18	12000	2.16
3	Printing of forms etc.	18	15000	2.70
<b>Total</b>				<b>9.36</b>

#### Vehicle Hiring and POL/Maintenance

Table – 4

S. No.	Office	No. of unit	No. of Vehicle	Rate per year/ per vehicle	Cost (lakh)
1	State Leprosy Office	1	2	85000	1.70
2	District Leprosy Office	18	18	100000	18.00
<b>Total</b>		<b>19</b>	<b>20</b>		<b>19.70</b>

#### IEC

Table – 5

S. No.	Medium	Cost (lakh)
1	Mass Media (TV Radio Press)	5.50
2	Outdoor Media (wall painting, Rallies, Hoarding etc.)	14.50
3	Rural Media (Folk shows, Health Melas etc.)	20.00
4	Advocacy meetings (IPC workshop, Meeting of opinion leaders, School quiz etc.)	10.00
<b>Total</b>		<b>50.00</b>

#### Training & Capacity Building

Table – 6

S. No.	Category & Type of Training	Unit	No. of Batches	Unit Cost in Rs.	Cost for the year
1	Technical & IEC training for newly appointed MOs (Rural & Urban) and RMAs – 04 days	950	32	29800	9.56
2	Re-orientation training of Medical Officer - 02 days	1650	55	17300	9.52



3	Technical & IEC training for Health Supervisor (M&F) – 03 days	700	23	16300	3.75
4	Technical & IEC training for Health Worker (M&F) – 03 days	2200	73	14050	10.26
5	Laboratory technicians training – 05 days	146	5	24100	1.21
6	Study Materials for above trainees	5646		50	2.82
<b>Total</b>		<b>5646</b>			<b>37.12</b>

### Disability Prevention & Medical Rehabilitation

Table – 7

S. No.	Item	Norm & rate	Cost (lakh)
1	MCR footwear	120 pair/ district per year @ Rs. 250/- per	5.40
2	Aids & appliances	Rs. 12,500/- District per year (18x12500)	2.25
3	Welfare allowance for RCS 150 patients	Rs. 5,000/- per patient	7.50
4	Support to Govt. hospitals for 150 RCS	Rs. 5,000/- per RCS	7.50
<b>Total</b>			<b>22.65</b>

### Urban Leprosy Control Programme

No. of urban areas identified for support

Table – 8

S. No.	Type of Urban Area	No.	Unit cost per year in Rs.	Cost (lakh)
1	Township	12	57000	6.84
2	Medium cities - I	2	120000	2.40
<b>Total</b>		<b>14</b>	<b>-</b>	<b>9.24</b>

- Supportive Medicine includes Prednisolone, Dressing materials and medicines.
- MDT delivery services and follow-up of under treatment patients.



iii) Monitoring, supervision and coordination which include periodic meetings and mobility.

**TOWNSHIP**

<b>District</b>	<b>Township</b>
1 Sarguja	Ambikapur
2 Koriya	Koriya
3 Janjgir	Janjgir
4 Durg	Durg
5 Durg	Bhilai
6 Rajnandgaon	Rajnandgaon
7 Korba	Korba
8 Raigarh	Raigarh
9 Kawardha	Kawardha
10 Bastar	Jagadalpur
11 Mahasamund	Mahasamund
12 Dhamtari	Dhamtari
<b>Medium Cities</b>	
1 Raipur	Raipur
2 Bilaspur	Bilaspur

**Supervision, Monitoring and Review**

**Review Meeting**

**Table – 9**

<b>S. No.</b>	<b>Activity</b>	<b>periodicity</b>	<b>Unit cost per meeting in Rs.</b>	<b>Cost (lakh)</b>
1	State level	Quarterly	15000	0.60
2	District level (18)	Monthly	2000	4.32
<b>Sub TOTAL</b>				<b>4.92</b>

**Travel Cost**



**Table – 10**

S. No.	Travel cost categories	Annual Rate per year in Rs.	Cost (lakh)
1	State	50000	0.50
2	Districts (18)	15000	2.70
<b>Total</b>			<b>3.20</b>

**Office Expenditure**

**Table – 11**

S. No..	Item	No. of units	Rate per year in Rs.	Cost (lakh)
1	Rent, Telephone, Electricity, P&T Charges, Misc.			
	Districts	18	20000	3.26
	State Leprosy Cell	1	50000	0.50
<b>Sub Total</b>				<b>3.76</b>
2	Office equipments maintenance cost			
	State Leprosy Cell	1	30000	0.30
<b>Total</b>				<b>4.06</b>

**Consumable**

**Table – 12**

Item	No. of units	Rate per year in Rs.	Cost (lakh)
<b>Stationary items</b>			
Districts	18	15000	2.70
State Leprosy Cell	1	50000	0.50
<b>Total</b>			<b>3.20</b>

**Cash Assistance**

**Table – 13**



Item	No. of units	Rate per year in Rs.	Cost (lakh)
Cash Assistance			20.00
Total			20.00
GRAND TOTAL			234.96
Two Crore Thirty Four Lakh Ninety Six Thousand			

Annexure - 2			
Component and Item-wise Cost for 2010-11			
NRHM Flexi pool (Summery)			
S. No.	Component	Item	Cost (lakh)
1	Disability Prevention & Medical Rehabilitation (DPMR)	Incentives to Surgeons for conducting Reconstructive Surgery	2.00
		Incentives to MPW (M&F) AWW, Voluntary workers, Dai for motivating leprosy affected person.	12.00
		Incentives to leprosy affected persons	15.00
2	Block Level Active Search	IEC & Door to Door search in 43 blocks.	99.44
3	Urban Leprosy sensitization & Awareness Campaign (ULSAC)	In 10 urban areas	10.25
TOTAL			138.69
One Crore Thirty Eight Lakh Sixty Nine Thousand			

( From NRHM Flexi pool )

S. No.	Component	Activity	No. of Units	Unit Cost (in Rs.)	Total Cost (Lakh)
1	Disability Prevention &	Incentives to Surgeons conducting RCS operations	200	Rs. 1,000/- each	2.00



	Medical Rehabilitation (DPMR)	Incentives to MPW (M&F), AWW, Voluntary workers, Dai for motivating leprosy affected person (Incentive to these workers is not given by GOI. However, Mitansins' incentives is given by GOI)	3000	MB-Rs. 500/- each case, for 1500 cases	7.50
				PB-Rs. 300/- each case, for 1500 cases	4.50
		Transportation Charges to leprosy affected persons for referrals to PHC, CHC & District Hospital.	3000	Rs. 500/- each	15.00
		<b>Sub Total</b>			<b>29.00</b>
2	Block Level Active Search	<p>15 days door to door search in 43 Blocks (List enclosed) having Prevalence Rate of more than 2 patients per 10,000 population as against the national target of 1 per 10000 population.</p> <p>For field work teams will be comprised of Health Supervisor, Health Worker (M&amp;F) and volunteer and TA/DA to be paid at the following rates-</p> <p>Health supervisor Rs. 70/- per day x 15 days = Rs. 1050/-</p> <p>Health Worker M Rs. 60/- per day x 15 days = Rs. 900/-</p> <p>Health Worker F Rs. 60/- per day x 15 days = Rs. 900/-</p> <p>Volunteer Rs. 45/- per day x 15 days = Rs. 675/-</p> <p>Rs. 3525/- per team</p> <p><b>Approx cost involved</b></p> <p>per Block :</p>	43	231250	99.44



		a) TA/DA Rs. 3525 x average 50 teams = Rs. 176250/- b) IEC = Rs. 20000/- c) Orientation of teams = Rs. 5000/- d) Mobility for supervision / IEC = Rs. 30000/- For all the identified blocks <b>Rs. 231250/-</b>			
		<b>Sub Total</b>			<b>99.44</b>

3	Urban Leprosy Sensitization & Awareness Campaign (ULSAC)	15 day - 10 ULSAC in 10 district (Raipur, Bilaspur, Janjgir, Durg, Rajnandgaon, Korba, Raigarh, Kawardha, Jagadalpur, Mahasamund)	10	102500	10.25
		Approx cost involved per ULSAC			
		a) TA/ DA Rs. 3525 per team x average 20 team = Rs.70500/-			
		b) IEC = Rs. 10000/-			
		c) Orientation of teams = Rs. 2000/-			
		d) Mobility for supervision/ IEC = Rs. 20000/-			
		Rs. 102500/-			
		<b>Sub Total</b>			<b>10.25</b>
		<b>GRAND TOTAL</b>			<b>138.69</b>



**Block Level Active Search in Block having more than 2 PR**

District	S. No..	Name of Block	District	S. No..	Name of Block
Raigarh	1	Sarangarh	Bastar	25	Nangur
	2	Baramkela		26	Tokapal
	3	Pusoor		27	Bakawand
	4	Tamnar	Bilaspur	28	Bilha
	5	Gharghoda		29	Kota
	6	Lailunga		30	Lormi
Mahasamund	7	Pithora		31	Marwahi
	8	Basna		32	Masturi
	9	Saraipali		33	Mungeli
	10	Mahasamund		34	Patharia
	11	Bagbahara		35	Pendra
Raipur	12	Bilaigarh		36	Takhatpur
	13	Simga	Janjgir	37	Pamgarh
	14	Arang	Durg	38	Nikum
	15	Dharsiwa		39	Dhamdha
	16	Kasdol	Jashpur	40	Pathalgaon
	17	Lawan	Kawardha	41	Kawardha
	18	Pallari	Korba	42	Katghora
	19	Tilda		43	Pali
	20	Gariaband			
	21	Abhanpur			
	22	Bhatapara			
	23	Deobhog			
	24	Mainpur			



National Leprosy Eradication Programme, Chhattisgarh

Issues to be taken up in State Health Secretaries Meeting in New Delhi

S. No..	Issues	Proposed Activity
1	<i>Involvement of ASHA : Involvement of ASHA is crucial at this stage of the programme so that suspected cases of leprosy could be detected and reported to PHC for diagnosis and treatment.</i>	<p><i>The process has already begun and further steps have been initiated to strengthen the implementation.</i></p> <p><i>In urban areas there are no ASHA (Mitandin) and therefore, we propose the involvement of AWW for this work by paying some incentive.</i></p> <p><i>In addition to this we are proposing to pay honorarium to MPW (M&amp;F), Voluntary Workers and Dais for motivating leprosy affected persons. It is also proposed to reimburse the transportation charges to leprosy affected persons for coming to PHC, CHC &amp; District Hospitals. (These activities are proposed to be funded from NRHM Flexi pool)</i></p>
2	<i>Leprosy Colonies : There are 14 leprosy colonies in the state where more than 1500 leprosy affected persons are residing. The state should ensure provision of proper health care facilities like ulcer care, provision of supportive drugs and dressing materials to the persons affected with leprosy residing in these colonies</i>	<i>This has already been taken care of through urban leprosy control programme in addition to the routine services. Patients have been provided with self care kit. The patients and dressers have been trained also for self care.</i>
3	<i>Supervision and Monitoring : Out of 16 districts, regular DLOs are posted in only 3 districts whereas in remaining 13 districts, DLOs are holding multiple charges. Post of full time DLO is</i>	<p><i>To resolve this issue we have proposed for posting 8 DLOs on contractual basis from NRHM flexi pool.</i></p> <p><i>We have proposed for 8 District Surveillance</i></p>



	<i>required in all districts for proper supervision and monitoring of the programme</i>	<i>Medical Officers, 12 Paramedical staff. 1 MDT Logistic Consultant and 6 Data Entry Operators from European Commission support. The selection process has already been completed.</i>
4	<i>Block Level Active Search : There are some 43 blocks of various districts which are the main contributors to state prevalence rate.</i>	<i>It is proposed to organize 15 days door to door search in these blocks under the support from NRHM flexi pool.</i>
5	<i>Operational Research : Since the state is having the highest PR in the country some basic studies are required to be under taken to find out the reasons.</i>	<i>Some studies like urban leprosy, Accompanied MDT, Trends of new cases, Gender factors, household contracts and under diagnosis are proposed to be made through Medical and Nursing Colleges under the financial support from NRHM flexi pool.</i>
6	<i>Infrastructure: The basic infrastructural facilities like office equipments (Computer, Printer and Photocopiers), Data Entry Operators, Drivers and Peon are urgently needed to strengthen the District Nucleus.</i>	<i>The items are proposed to be met from NRHM flexi pool.</i>  <i>The lack of independent/ separate office for District Nucleus team also causes lot of inconvenience in the smooth functioning for which construction of office in 6 districts is proposed to be undertaken from European Commission support.</i>
7	<i>WHO State Coordinator : The post of WHO State NLEP Coordinator is lying vacant.</i>	<i>GOI has vide letter NO. D.O. No. M-12014/9/2003-Lep (Coordination) Dated. 21.10.09 informed that the post will be filled up w.e.f. 1st January 2010.</i>



## H. NPCB

### H. National Programme for Control of Blindness

1. **Strengthening of Medical Colleges Grant-in-aid for strengthening of Medical Colleges.** Non-recurring assistance up to Rs. 40 lakhs for providing ophthalmic equipments as commodity assistance for development of paediatric eye units/ low vision units/retina units, audio visual aids, IOL surgery & all other subspecialties etc. for Medical College Jagadalpur.

### 2. **Strengthening of District Hospitals Grant-in-aid for strengthening of District Hospitals**

**Non-Recurring assistance** up to Rs. 20 lakhs for ophthalmic equipments for IOL surgery /SICS/Phaco-emulsification/ glaucoma management etc. and audio visual aids, IOL, sutures etc.

**Following District Hospitals are proposed to be strengthen during the year 2010-11:-**

1. **District Hospital Janjgir.**
2. **District Hospital Kawardha**
3. **District Hospital Rajnandgaon**
4. **District Hospital Dhamtari.**

### 3. **Up gradation of Sub-dist. Hosp/ CHCs Grant-in-aid for strengthening of Sub-District Hospitals**

Non-recurring assistance up to Rs. 5 lakhs for ophthalmic equipments for IOL Surgery/SICS, IOL, Sutures etc.

**Following Sub-District Hosp/CHCs has been upgraded to FRUs by the state Govt and OTs have been constructed. This FRUs are proposed to be upgraded to Microscopic centres under NPCB:-**

1. **CHC Kasdol District -Raipur**
2. **CHC Chhura District -Raipur**
3. **CHC Bakawand District -Bastar**
4. **CHC Chhindgarh District -Dantewada**
5. **CHC Bagicha District -Jashpur**
6. **CHC Sahaspur Lohara District -Kawardha**
7. **CHC Lailunga District -Raigarh**



8. CHC Magarlod District -Dhamtari
9. CHC Gorella District -Bilaspur
10. CHC Basna District -Mahasamund
11. CHC Dhamdha District -Durg
12. CHC Mohla District -Rajnandgaon
13. CHC Antagarh District -Kanker
14. CHC Pali District -Korba
15. CHC Ramanujganj District -Sarguja
16. CHC Rajpur District -Sarguja

4. Vision Centres at PHCs/ in Vol. Sector Grant-in-aid for PHC/Vision Centres in Government and Voluntary Sector

**Non recurring assistance up to Rs.50,000 for basic equipments, furniture and fixtures etc. GIA to DBCS would be used for Vision Centres at PHCs in Govt. and Voluntary Sector .**

During 2010-11, 36 Vision centres 2 in each districts will be proposed to be developed in Govt / voluntary Sector. Rs.18 Lakhs are required.

5. Non recurring GIA for strengthening/ expansion of Eye Care units Non-recurring Grant-in-aid to District Health Societies (NPCB) for release to NGOs for strengthening/expansion of Eye Care Units in rural and tribal areas @ Rs.30 Lakhs.

1 NGO Eye Hospital Chandulal Chandraker Hospital, Bhilai is proposed to be Strengthen during the year 2010-11.

#### **6.Appointment of Ophthalmic Surgeons**

Appointment of one Ophthalmic Surgeon @ Rs.25000/- P.M. in the following District Hospitals:-

1. District Hospital, Narayanpur
2. District Hospital, Jashpur
3. District Hospital, Bijapur
4. District Hospital Dantewada
5. District Hospital Kawardha.
6. Budget Required for 5 Eye Surgeons Per Annum is Rs.15 Lakhs.
1. Free Spectacles to School age children.

**Approx 11 Lakhs School going children are to be examined. Refractive error @ 6% become 66000 out of these 30% are BPL which comes to 19800 to whom we will give spectacles. The fund required is 19800 X 200=39.6 Lakhs.**



**8. Training of Ophthalmic and support manpower Training of Eye Surgeons and other eye care personnel**

**State/District Level.** Training in Ophthalmic Nursing, training of PMOAs, refresher training of MOs PHC/CHC/DH and PMOAs will be organized at state level. Basic training of Ophthalmic Assistants will be revamped and initiated in selected institutions of the country.

Training of State and District Programme Managers, ASHA & ICDS etc. will

also be organized at state level The above trainings will be organized as per the approved financial norms.

S. No	Personnel	No. to be trained	Place of Training	Period	Unit Cost	Batch	Total Required
1	Staff Nurse	16	Medical College	1 Month	160000	2	160000
2	TOT 2 person from each District	32	SIHFW	1 Day	25000	32	25000
3	Newly recruited PHC Medical Officer	250	District Level	3 Days	55800	8	460000
4	RMA	700	District Level	3 Days	55800	23	1322500
							1967500

**9. Information Education Communication (IEC) (Rs. in Lakhs)**

1	100 Hoardings for three Months	100	Rs. 8000X100	8.00
2	Wall Paintings one for PHC/CHC Villages & Towns	2000	Rs. 250X2000	5.00
3	Nare 2 per village	20000X2	Rs. 10X40000	4.00
4	Video Spot/ Scroll for One Month	4 Channels	Rs. 50000X4	2.00
5	Radio jingles for a Month	6 Channels	Rs. 50000X6	3.00



6	Scroll Panels for 18 District Hospital	15000	Rs. 15000X18	2.70
7	Sensitization Workshop of AWW at PHC/CHC Level	850	Rs. 500X850	4.25
8	PRIs Member Sammelans CHC/ PHC level	850	Rs. 500X850	4.25
9	Flex Posters for DH/CHC/PHC/SHC& Panchayat .	16000	Rs.35X16000	5.60
10	State Level IEC Activities for EYE Donation Fortnight	1		0.50
11	District /Block IEC Activities for EYE Donation Fortnight	146	Rs. 3500X146	5.11
12	State Level IEC Activities for World Sight day	1		4.00
13	State/ District /Block IEC Activities for World Sight day	146	Rs. 5000X146	7.30
14	Video Spot and Jingles Advt. in Video Albums and Audio Songs	5		2.00
15	Audio Song and Jingles Production	8		0.39
	<b>Total</b>			<b>58.10</b>

**10. Maintenance of Ophthalmic Equipments Non-recurring Grant-in-aid for maintenance of Ophthalmic Equipments (New initiative)**

Non-recurring assistance up to Rs. 5 lakh per unit for maintenance of Ophthalmic equipments supplied to RIOs, Medical Colleges, District/Sub-District Hospitals, PHC/Vision Centres to ensure longevity of costly ophthalmic equipments supplied under the programme to all the DBCS.

16 DBCS @ Rs.1 Lakhs Rs.16 Lakhs are required

**11. Free Cataract Operations**

60000 cataract operation will be performed by NGO sector payment @ Rs.750/- per case Rs. 450 Lakhs is required for 2010-11.

**12.Free Cataract Operations (Incentive to Mitnin) @ Rs.175 per Case**



40000 Cataract operations will be done by private practioners Rs.175 will be given to Mitantin as incentive

40000X175 =70 Lakhs are required.

### 13.Other Eye Diseases

Treatment of other diseases @ Rs,1000/-per case for 1000 cases Rs.10 Lakhs is required.

### 14.Private Practioners

Private Practitioners will be involved in Sub-District, Block and village levels for cataract operations and treatment of other diseases. For 1000 cases @ Rs.750/- Rs.7.5 Lakhs will be required.

### 15. State Health Society (NPCB) Grant-in-aid for management of State Health Society (NPCB)

Recurring grant-in aid of Rs. 14.00 lakhs per annum to meet the cost on salary of the following staff (one post each), TA/DA, organizing review meetings, hiring of vehicle, operating and maintenance of office equipments and contingencies.

Budget and Finance Officer

Administrative Assistant/Statistical Assistant

Data Entry Operator/Steno/LDC

Group D

Rs.14 lakhs is required during the year 2010-11.

### 16 Recurring GIA for Eye Donation Centres

Recurring assistant of Rs.1000 per pair of eyes to Eye Donation Centres

Year	Target	Fund Required @ 1000 per pair
2010-11	250	250000

### 17 Recurring GIA for Eye Banks

Recurring assistance of Rs.1500 per pair of eyes towards honorarium of Eye Bank staff, consumables including preservation material & media, transportation/ POL and contingencies.



Year	Target	Fund Required @ 1500 per pair
2010-11	250	375000

**18.Procurement of Ophthalmic Equipments.:-**

**For Procurement of IOLs, Sutures requirement of Funds are as below:-**

(Rs. in Lakhs)

Sr. No	Item	Total Requirement	Unit Cost	Total Cost
1	I.O.L	60000	100	60
2	Sutures 8-0	2500 Doz	2200	55
3	Sutures 10-0	800 Doz	2500	20
			Total	135

**19.Appointment of Ophthalmic Assistant on contractual towards salary.**

Applications for 10 Ophthalmic Assistant to be appointed in the year 2009-10 has been received and will be appointed soon. Salary for 10 ophthalmic Assistants @ 8000/- per month Rs.9.6 Lakhs is required for 2010-11.

Ophthalmic Assistants will be posted in the following Districts:-

1.District Hospital, Narayanpur

2.District Hospital, Jashpur

3.District Hospital, Bijapur

4.District Hospital Dantewada

5.District Hospital Kawardha.

6.District Hospital Koriya

7.District Hospital Kanker

8.District Hospital Korba

9.District Hospital Jagadalpur

10.District Hospital Janjgir



## **20. Construction of dedicated Eye wards & Eye OTs Non-recurring Grant-in-aid for construction of dedicated Eye Wards and Eye OTs (New initiative)**

**Non-recurring assistance** through State Health Society (NPCB) for Construction of Eye Wards and Eye OTs .

In Chhattisgarh State 45% population is Tribal ST & ST and near about 40% area is forest and hilly area. These areas are medically underserved and requires dedicated OTs and Wards along with Mobile Van. Following places are proposed for sanctioned of OTs & Wards.

1.	District Hospital Bijapur	20 Bedded EYE Ward & OT
2.	District Hospital, Narayanpur.	20 Bedded EYE Ward & OT
3.	District Hospital Mahasamund.	20 Bedded EYE Ward & OT
4.	District Hospital, Bilaspur.	20 Bedded EYE Ward & OT
5.	District Hospital, Janjgir	20 Bedded EYE Ward & OT
6.	District Hospital, Dantewada.	20 Bedded EYE Ward & OT
7.	Civil Hospital, Bemetara.	10 Bedded EYE Ward & OT
8.	CHC Bhanupratappur, District Kanker.	10 Bedded EYE Ward & OT
9.	CHC Deobhog, District Raipur.	10 Bedded EYE Ward & OT
10.	CHC Chowki, District Rajnandgaon.	10 Bedded EYE Ward & OT

*District Hospital Bijapur ,Narayanpur & Bilaspur is a new District Hospital*

District Hospital, Mahasamund, , Janjgir & civil hospital Bemetara- under World Bank project Eye ward & OT was constructed in old hospital. At present in all these District HQ. new 100 Bedded District Hospital has been constructed by State Govt., which is quite away from the old hospital. In CHC Bhanupratappur, Deobhog & Chowki regular institutional operations are being carried on by Mobile units of the concerned District Equipment for IOL surgery is available, only Eye OT & 10 Bedded ward is required.

20 Bedded Hospital @ Rs.20 Lakhs unit cost for above 6 Places Rs 20X6=120 Lakhs is required & for 4 10 Bedded Hospital & OTs @ Rs.12 Lakhs Rs.48 Lakhs Totalling to Rs. 168 Lakhs are required during 2010-11.

## **21. Mobile Ophthalmic Units with Tele- Ophthalmic Network Grant-in-aid for Development of Mobile Ophthalmic Units with Tele-Ophthalmic Network and few fixed Tele-Models**



**Non-recurring assistance** up to Rs. 60 lakh towards development of Mobile Ophthalmic units with Tele- Ophthalmic Network and few fixed Tele-Models. The assistance for Mobile Van with essential ophthalmic equipments is up to Rs.20 lakh. The assistance for Tele-Ophthalmic Network/Tele-Model is up to Rs.40 lakh.

No fund is required for 2010-11 under this head.

22. Support to Eye Donation Centres in Govt./ Voluntary Sector Grant-in-aid for Eye Donation Centres in Government/Voluntary Sector .

During 2010-11, 7 District Hospitals are proposed to be developed :-

1.District Hospital Dhamtari

2.District Hospital Kanker

3.District Hospital Rajnandgaon

4.District Hospital Mahasamund

5.District Hospital Korba

6.District Hospital Janjgir

7.District Hospital Raigarh

23.Recurring assistance of Rs.10,000 per month for appointment of one Eye Donation Counsellor on contractual basis towards salary .

Year	Existing Eye Bank	Existing Eye Bank to be Strengthening	New Eye Bank to be developed	Total Eye Bank/ No .of Counsellor Required	Fund Req. @10000 per Month
2010-11	3 ( Medical College, Raipur, Aravindo Eye Hospital, MGM Eye Institute)		1 (District Hospital Bilaspur)	4	480000

24.Training of MPW (Male) & MPW(Female)

Training of MPW(Male) & Female will be done in all the 146 blocks. This will increase the detection of cataract patients & other eye diseases in village level resulting to increase in



number of cataract operations and referral & early diagnosis of other diseases like diabetic retinopathy, Glaucoma etc.

Trainee	Poste d	Batch@ 15 for MPW/ 30 for ANM	Per Diem for trainee	Per Diem/Ho norarium for trainer	Refreshm ent per person	Course Material Per Participa nt	Organiz ation Expens es Per Course	Estimated total Expenditure
MPW	2581	172	150	300	150	100	700	1204400
ANM	4633	154	150	300	150	100	700	2007200
Total								3211600

## 25.Incentive to School Teachers:-

The school children belonging to BPL category are given spectacles by the DBCS. Some of them do not use them or use irregularly. To motivate such children to use the spectacles regularly and to monitor them the school class teachers will be given Rs.25/- per case. For 20000 cases @ Rs.25/- Rs.500000 is required.

**Total Rs.5,00,000/- is required under this head.**

## 26.Performance Bonus to Eye Surgeons

In Chhattisgarh there are 63 eye surgeons in Govt. sector. But the operating Surgeons are only 20-25%. To motivate the non-operating surgeons the performance bonus will be given at the following rate. Every surgeon will have to perform 700 cataract operations. After 700 cases they will be given Rs.10,000/- in every increase in 100 cases.

### (a) For Govt. Eye Surgeons-

Up to 800 Cases another Rs.10000

Up to 900 cases another Rs.10000

Up to 1000 cases another Rs.10000

Up to 1100 cases another Rs.10000

Rs.10000 for every increase in 100 cases.

### Computation of Requirement of Total Fund

In the year 2008-09 following are the Number of Eye Surgeons performed 800 and more cataract operations:-



No of Cataract Operations	No of Surgeons	Bonus	Total
800	2	10000X2	20000
900	3	20000X3	60000
1000	3	30000X3	90000
1300	2	60000X2	120000
1500	3	80000X3	240000
2000	1	130000X1	130000
2500	1	180000X1	180000
3000	1	230000X1	230000
Total			1070000

Approx Rs.1070000/- is Required

**(b) For Private Eye Surgeons:-**In Government facilities many private Eye surgeons are going for cataract operation. They are now showing unwillingness as this is hampering their private practice. To motivate and compensate the loss the Private Eye surgeons operating at Govt. facilities will be given performance bonus @ Rs.100 per case. For Approx 1000 Cases X 100= Rs 10 Lakhs is Required

Total (a) & (b), Rs.10,70,000/-+Rs.10,00,000/-=20,70,000/-

## 27.Transportation of Surgeon & Team

The eye surgeons have not been allotted any government vehicle for conducting cataract operation at fixed facility of the district & other districts. Hence they are finding difficulties in transportation to & fro for eye operations.

To Operate in outside the head quarter (in other districts) Rs.3000/- Per Visit.

To Operate fixed day service within the district Rs.2000/- per visit.

One District to Other District 30 visit X3000 =Rs.90000/-

Within the District in 146 Block once in 2 month in each block 146X6=876

876XRs.2000=Rs.17,52,000/-

**Total Fund Required Rs.90000+17,52,000/- = Rs.18,42,000/-**

National Programme for Control of Blindness, Chhattisgarh			
S. No.	Budget Head	(Rs in Lakhs)	
		Physical Target	Funds Required for 2010-11



1	GIA For Strengthening of Medical Colleges @ Rs.40 Lakhs	1	40
2	Strengthening of District Hospitals @ 20 Lakhs	4	80
3	Up gradation of Sub-District hospital/community health centre @ Rs.5 Lakhs	16	80
4	Restructuring Vision Centres at PHC/ Voluntary Org @ Rs.50000	36	18
5	Non recurring GIA for NGOs @ Rs.30 Lakhs	1	30
6	Appointment of Ophthalmic Surgeon (Salary of Rs.25000/- P.M.)	5	15
7	School Eye Screening Programme	19800	39.6
8	Training		19.68
9	IEC		58.1
10	Maintenance of Ophthalmic Equipments		16
11	Free Cataract Operations @ Rs.750 per case	60000	450
12	Free Cataract Operations(Incentive to Mitnin @ Rs175 per case	40000	70
13	Other Eye Diseases@ Rs.1000 per case	1000	10
14	Private Practioners	1000	7.5
15	Management of State Health Society, Remuneration, other activity & Contingency		14
16	Recurring GIA to Eye Donation Centres	250	3.75
17	Recurring GIA to Eye Banks	250	2.5
18	Procurement of Ophthalmic Equipments		135
19	Appointment of Ophthalmic Assistant (Salary of Rs.8000/- P.M.)	10	9.6
20	Non Recurring GIA for Eye Wards & Eye OTs@ Rs.75 Lakh	10	168
21	Non Recurring GIA for Mobile Ophthalmic units with tele-network@ Rs.60 Lakhs	0	0
22	Eye Donation Centres@ Rs.1 Lakh	6	6
23	Eye Donation Counsellor(Salary of Rs.10000/- P.M)	4	4.8
24	Training of MPW Male & MPW Female		32.11
25	Incentive to School Teachers		5
26	Performance Bonus to Eye Surgeons		20.7
27	Transportation of Eye Surgeons & Team		18.42
	Total		1353.76



# I RNTCP

## Introduction

The Revised National TB Control Programme (RNTCP), based on the internationally recommended Directly Observed Treatment Short-course (DOTS) strategy, was launched in 1997 expanded across the country in a phased manner. Full nationwide coverage was achieved in March 2006 covering over a billion populations (1114 million) in 632 districts / reporting units.

The State of Chhattisgarh has been successful in implementing the Revised National Tuberculosis Control Programme (RNTCP) across its 16 districts achieving full coverage on 15.08.04.

Name of District	Date of implementation
Raipur, Durg, Bilaspur, Rajnandgaon	15 <sup>th</sup> August 2002
Damtari, Kanker, Janjgir, Raigarh, Kawardha	26 <sup>th</sup> January 2004
Mahasamund	24 <sup>th</sup> March 2004
Korba, Jashpur	5 <sup>th</sup> May 2004
Bastar	29 <sup>th</sup> May 2004
Koriya, Sarguja, Dantewada	15 <sup>th</sup> August 2004

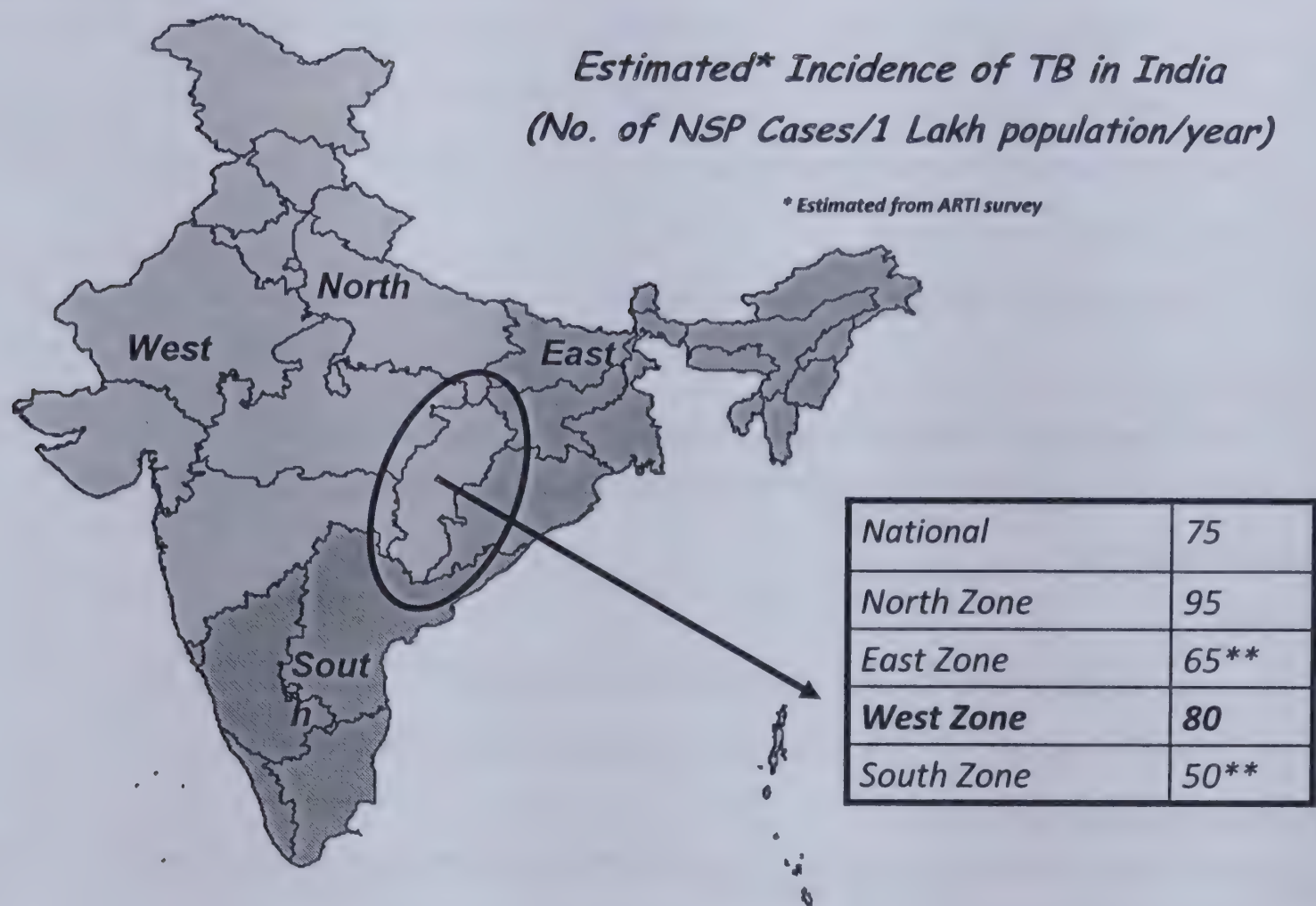
The goal of the TB control Programme is to decrease mortality and morbidity due to TB and cut transmission of infection until TB ceases to be a major public health problem in India. Early diagnosis and cure of sputum smear-positive patients can break the chain of services to all patients including both pulmonary and extra-pulmonary TB patients.

## Objectives of RNTCP:

1. To achieve and maintain a cure rate of at least 85% among newly detected infectious (new sputum smear-positive) cases, and
2. To achieve and maintain detection of at least 70% of all such cases in the population.

## Epidemiological Situation of TB in Chhattisgarh





With an Annual Risk of TB Infection (ARTI) of 1.6%, in Chhattisgarh which falls in west zone it is estimated that in per lakh population there would be:

- 80 New Smear Positives,
- 80 New Smear Negatives,
- 40 Smear Positive Re-treatment cases (Relapse, Failure, Treatment after Default)
- 16 New Extra-pulmonary cases.

Thus a total of around 216 patients of all types of TB are expected to exist per lakh population.

#### State Profile under RNTCP

Population	2,44.12 Lakh
No. of districts	18*
No. of TUs	62

(TB units for every 5 Lakh Populations in non tribal area & for every 2.5 Lakh populations in tribal & hilly area)

No. of DMCs	287
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(Designated Microscopic Centre is for every 1 Lakh Population in non tribal area & for every 50, 000 population in tribal & hilly area)

- No. of DOT Centres 5836

(Directly Observed Treatment Centres)

- No. of Medical Colleges 3
- Percentage of tribal population 32%

\* Two new districts (Bijapur and Narayanpur) have been formed in the state in the year 2008-09. Under RNTCP these needs to be separated and new DTCS has to be created.

### Human Resource

#### A) State

- Director (H&FW) – Dr R. K. Rajmani (Trained in RNTCP)
- State TB Officer – Dr D N Dewangan - In place (Trained in RNTCP).

#### B) State TB Cell (as of 3Q09)

Post	Sanctioned	In place
State Medical Officer	1	0
TB/HIV Coordinator	1	0
Microbiologist	1	1
Accountant	1	1
IEC Officer	1	1
Pharmacist	1	1
Data Entry Operator	1	1
Secretarial Assistant	1	0
Driver	1	1

#### C) State Training & Demonstration Centre (STDC) & IRL (as of 3Q09)

Post	Sanctioned	In place	Trained
STDC Director	0	0	NA
Epidemiologist	1	0	NA
Microbiologist	1	1	EQA



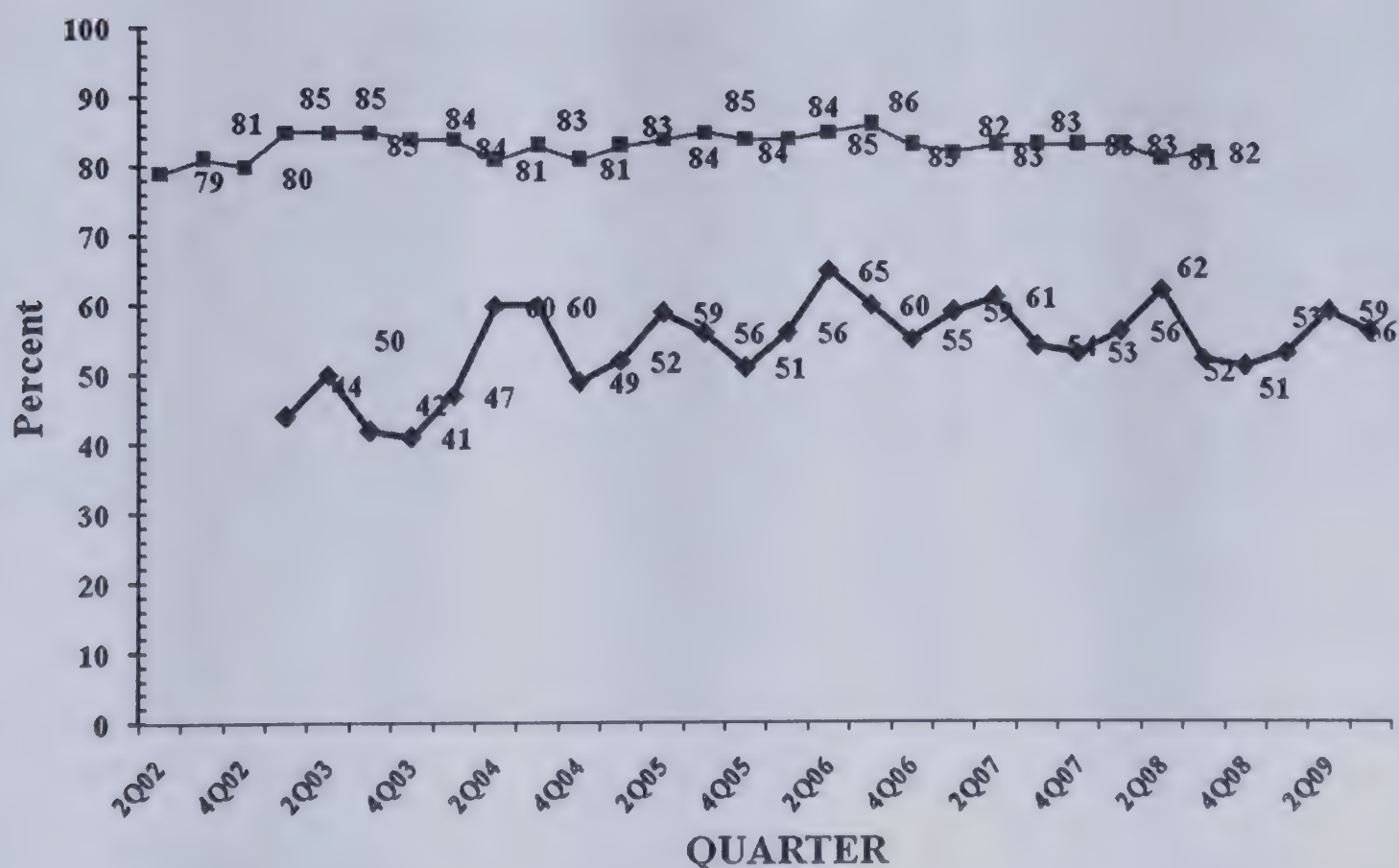
Technical Officers	2	0	NA
LT	0	2	Modular
Lab Assistant	3	0	NA

#### D) Districts (as of 3Q09)

		Sanctioned	In place	
			State Government staff	Contractual under RNTCP
1.	No. DTOs in post:	8	16 (2 Full time)	0
2.	No. of MO-TCs in post	59	53	0
3.	No. of STS in post	62	0	48
4.	No. of STLS in post	62	0	50
5.	No. of LTs of DMCs	287	159	97

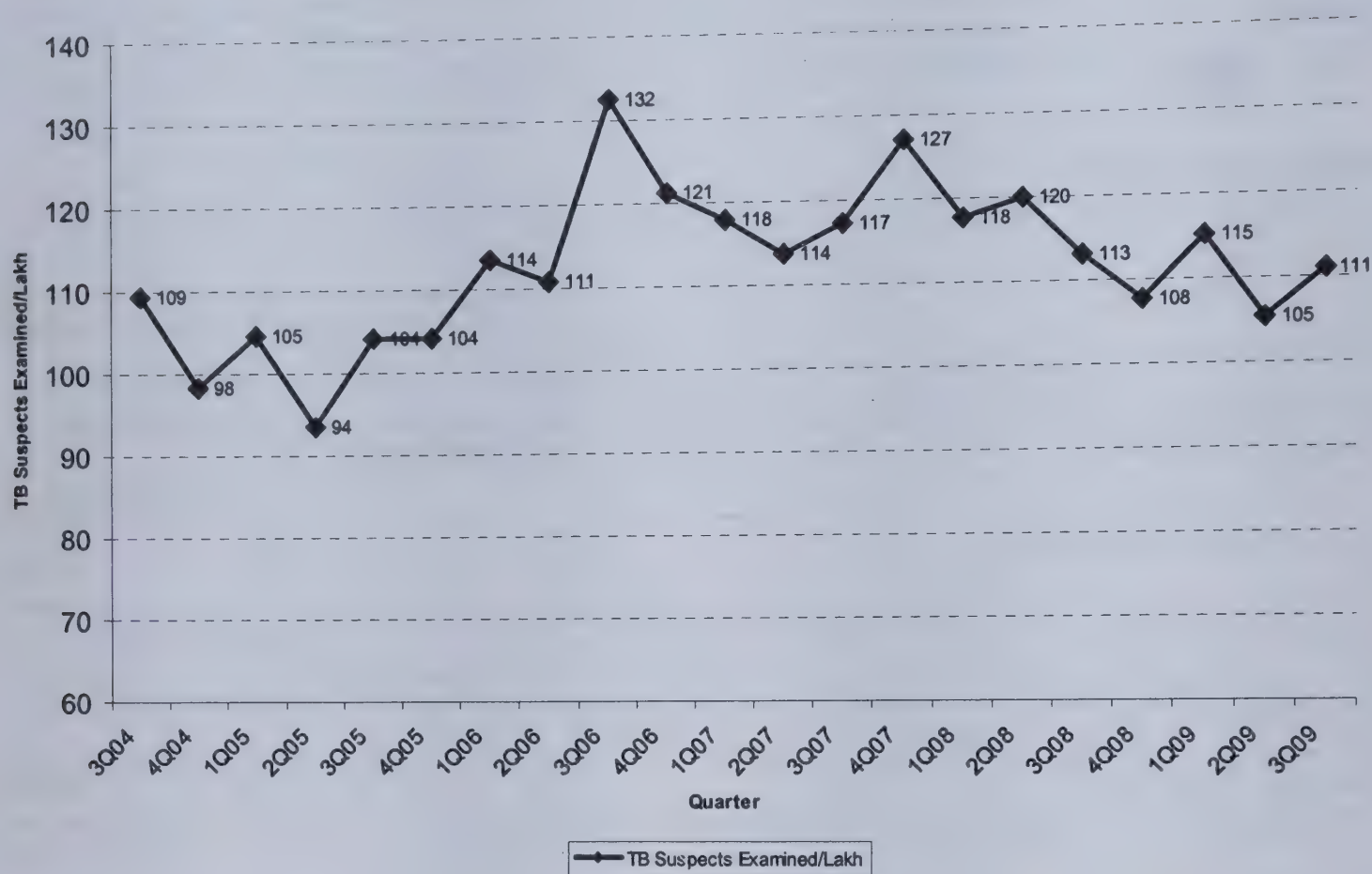
#### State's Performance for last 5 years

ACDR-NSP & NSP Cure Rate of the State

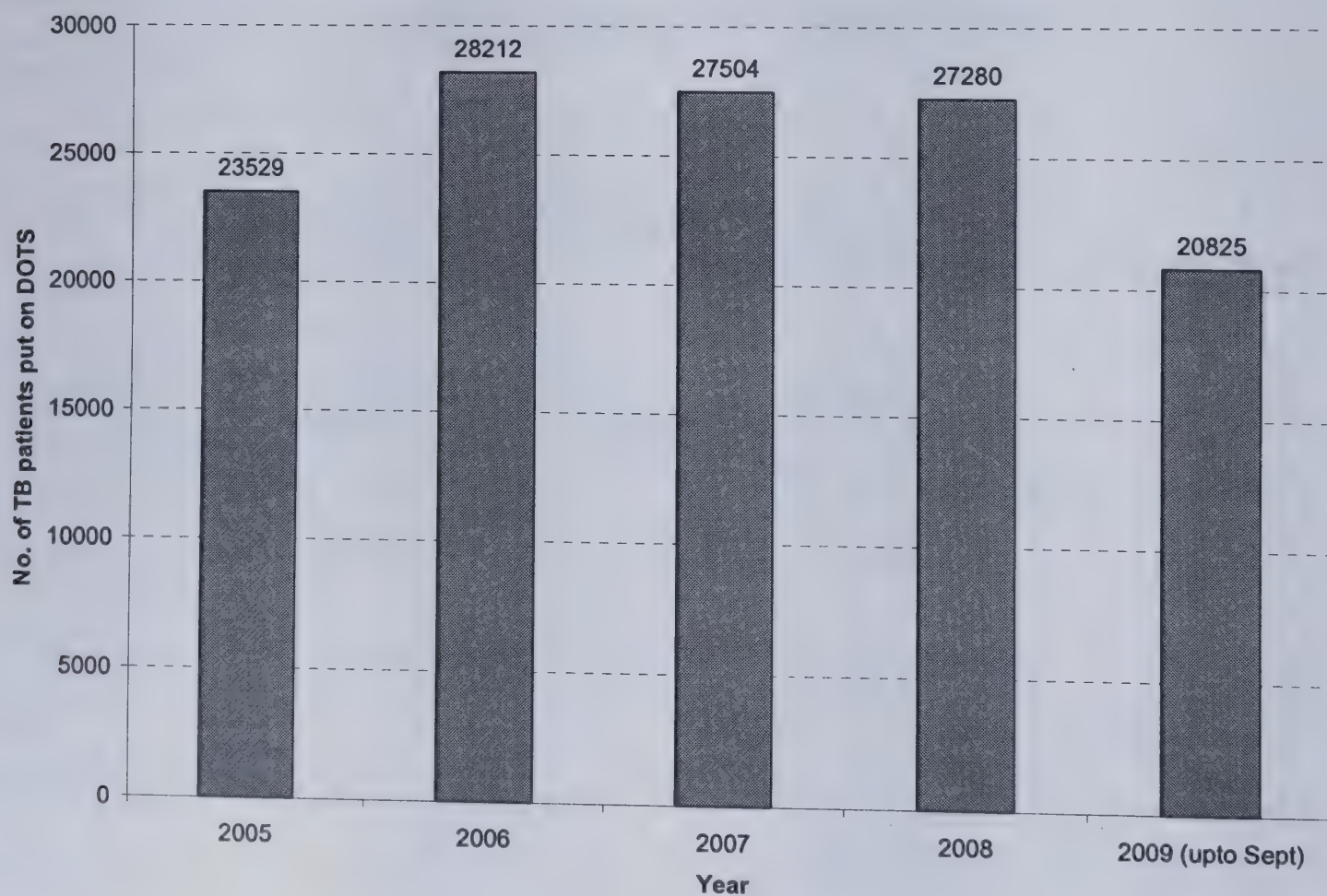




### Trends of TB Suspects examined per Lakh population for last 5 years



### Number of TB Patients put on DOTS (Year 2005 to September 2009)





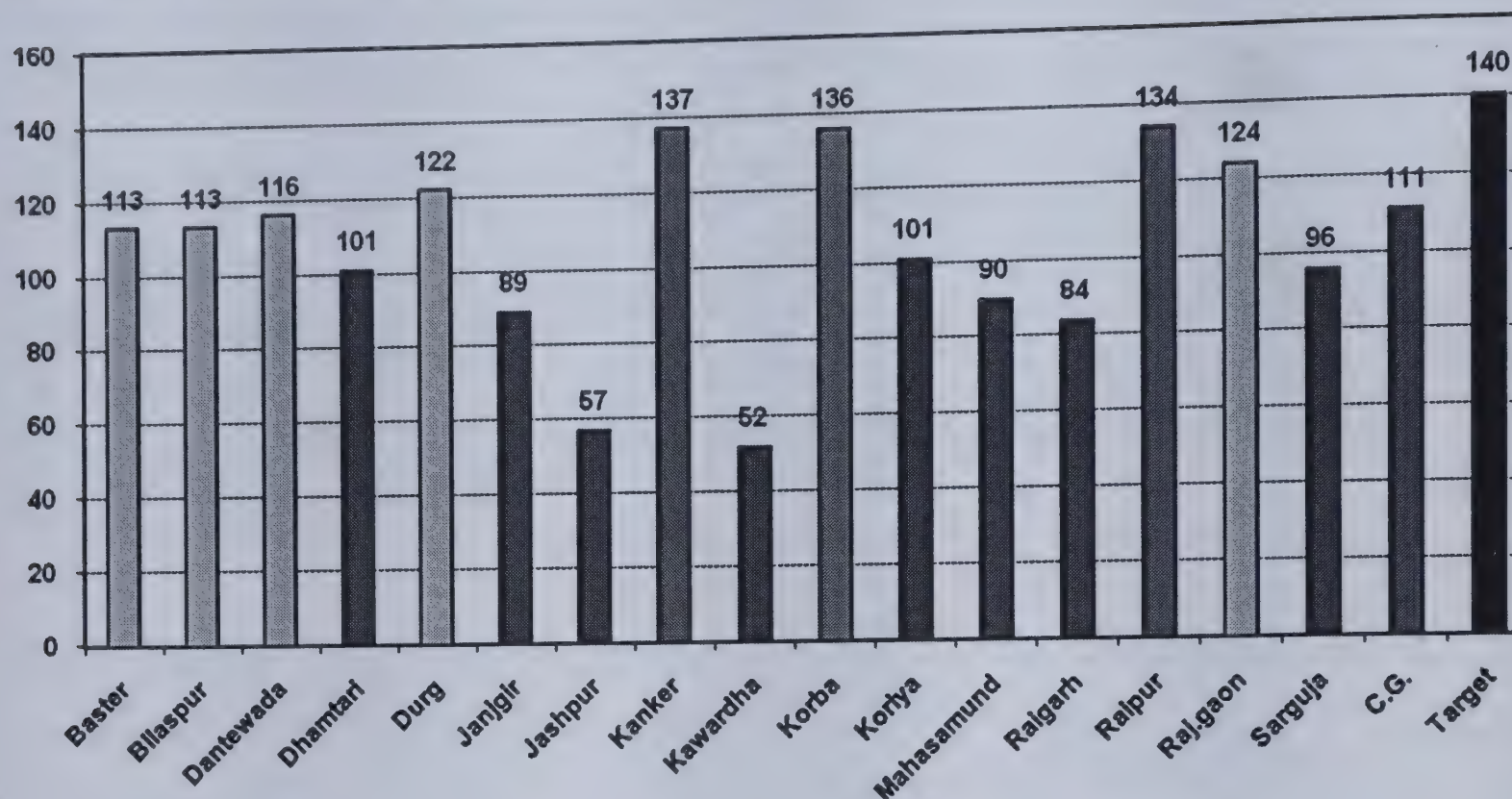
### District wise performance of the State (4Q08 to 3Q09)

As of September 2009 the state has successfully put 20,825 total TB cases on DOTS out of which 8080 patients were New Smear Positive (NSP) cases. Districts Kanker, Korba, Raigarh, Raipur & Rajnandgaon were in the target zone in 3Q09 where they have achieved both the objectives of RNTCP.

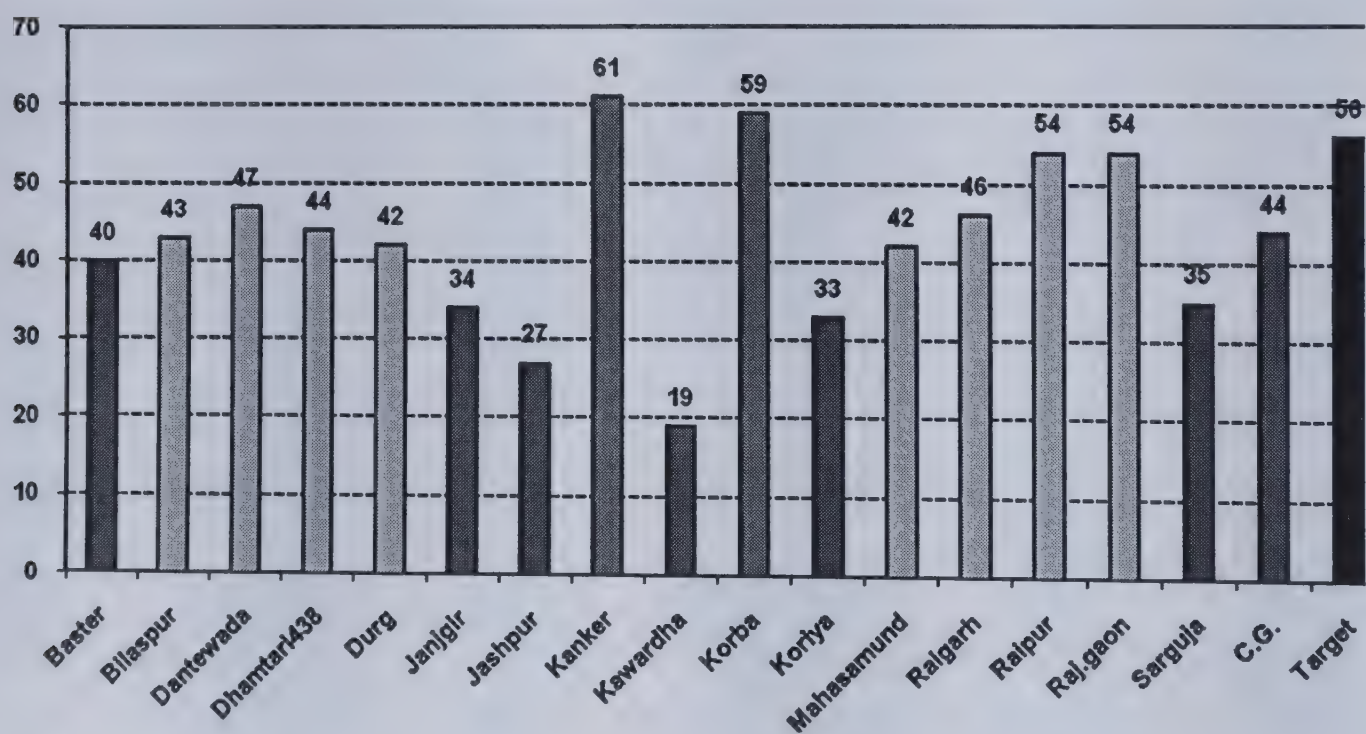
Name of the District (also indicate if it is notified hilly or tribal district	Total number of patients put on treatment*	Annualised total case detection rate (per lakh pop.)	No of new smear positive cases put on treatment *	Annualised New smear positive case detection rate (per lakh pop)	Cure rate for cases detected in the last 4 corresponding quarters	Plan for the next year	
						Annualized NSP case detection rate	Cure rate
Bastar	1682	112	603	40	53	45 (56%)	80%
Bijapur	174	62	102	36	65.3	41 (51%)	80%
Narayanpur	159	124	69	54	63.6	54 (67%)	80%
Bilaspur	2736	119	995	43	82	50 (62%)	85%
Dantewada	558	102	283	52	73	50 (62%)	80%
Dhamtari	705	87	360	44	90	50 (62%)	90%
Durg	4026	125	1346	42	86	50 (62%)	86%
Janjgir	1437	95	518	34	89	41 (51%)	89%
Jashpur	570	67	227	27	76	41 (51%)	80%
Kanker	969	129	456	61	82	61 (76%)	85%
Kawardha	347	52	127	19	63	41 (51%)	80%
Korba	1692	145	692	59	91	59 (74%)	91%
Koriya	673	100	224	33	75	41 (51%)	85%
Mahasamund	1122	113	413	42	82	45 (56%)	85%
Raigarh	1614	111	668	46	76	50 (62%)	85%
Raipur	4482	129	1871	54	85	56 (70%)	88%
Rajnandgaon	1994	135	804	54	83	56 (70%)	88%
Sarguja	2451	108	797	35	90	41 (51%)	90%
Total	27058	115	10384	45	82	48 (60%)	85%



**TB Suspects Examined per lakh population (4Q08 to 3Q09)**

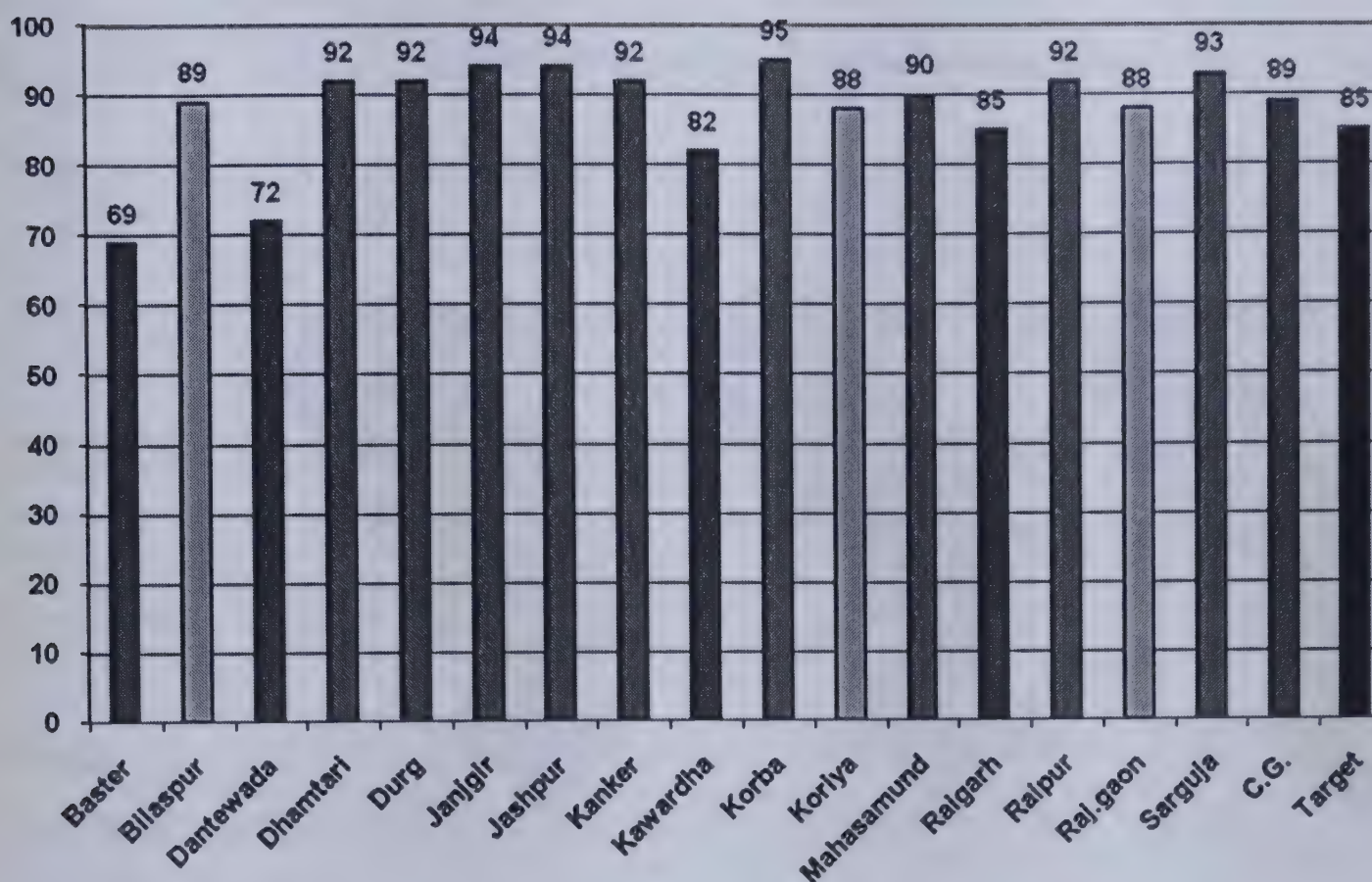


**Annualized Case Detection Rate for New Smear Positive Cases (per lakh)**

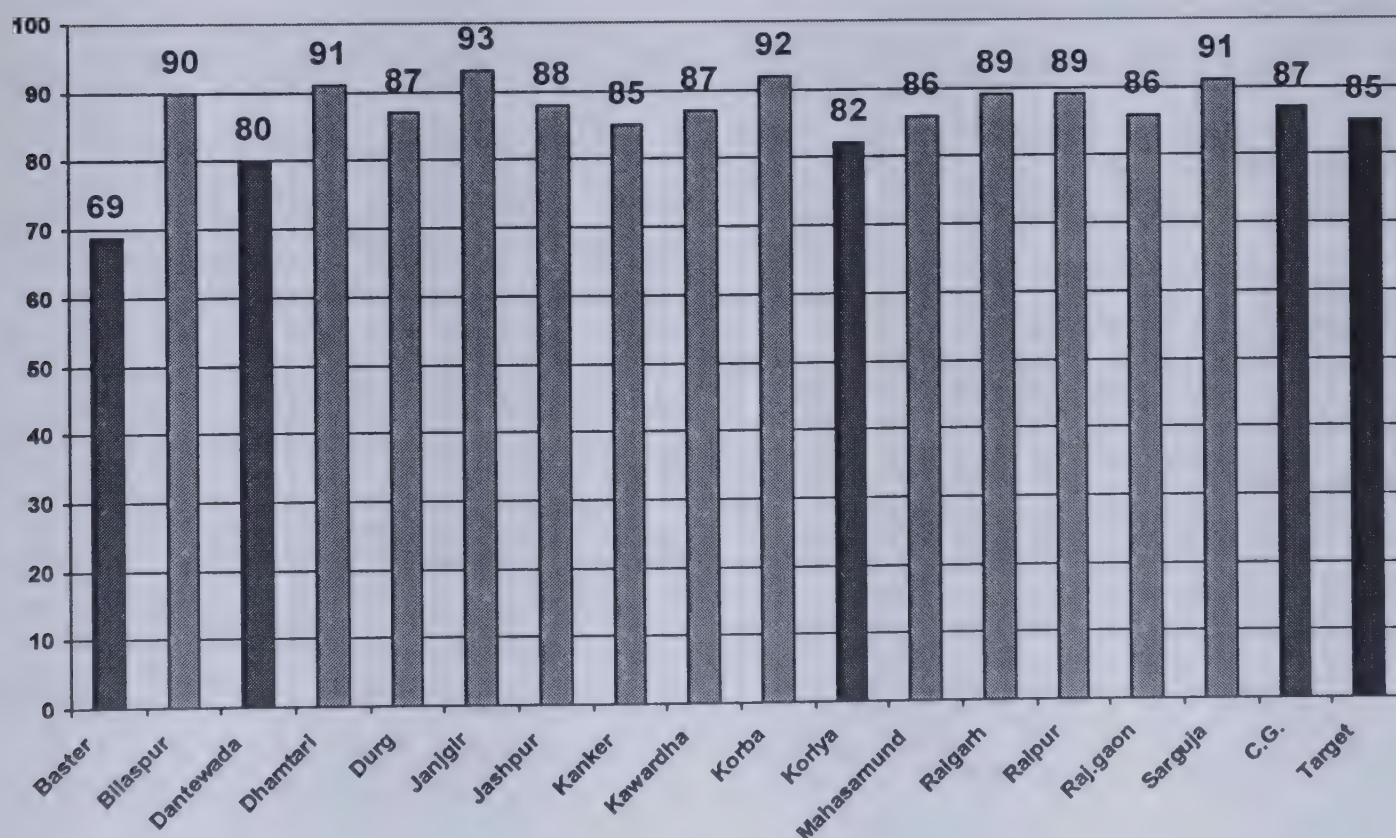


**Sputum Conversion Rate (%) for patients registered in 3Q08 to 2Q09**





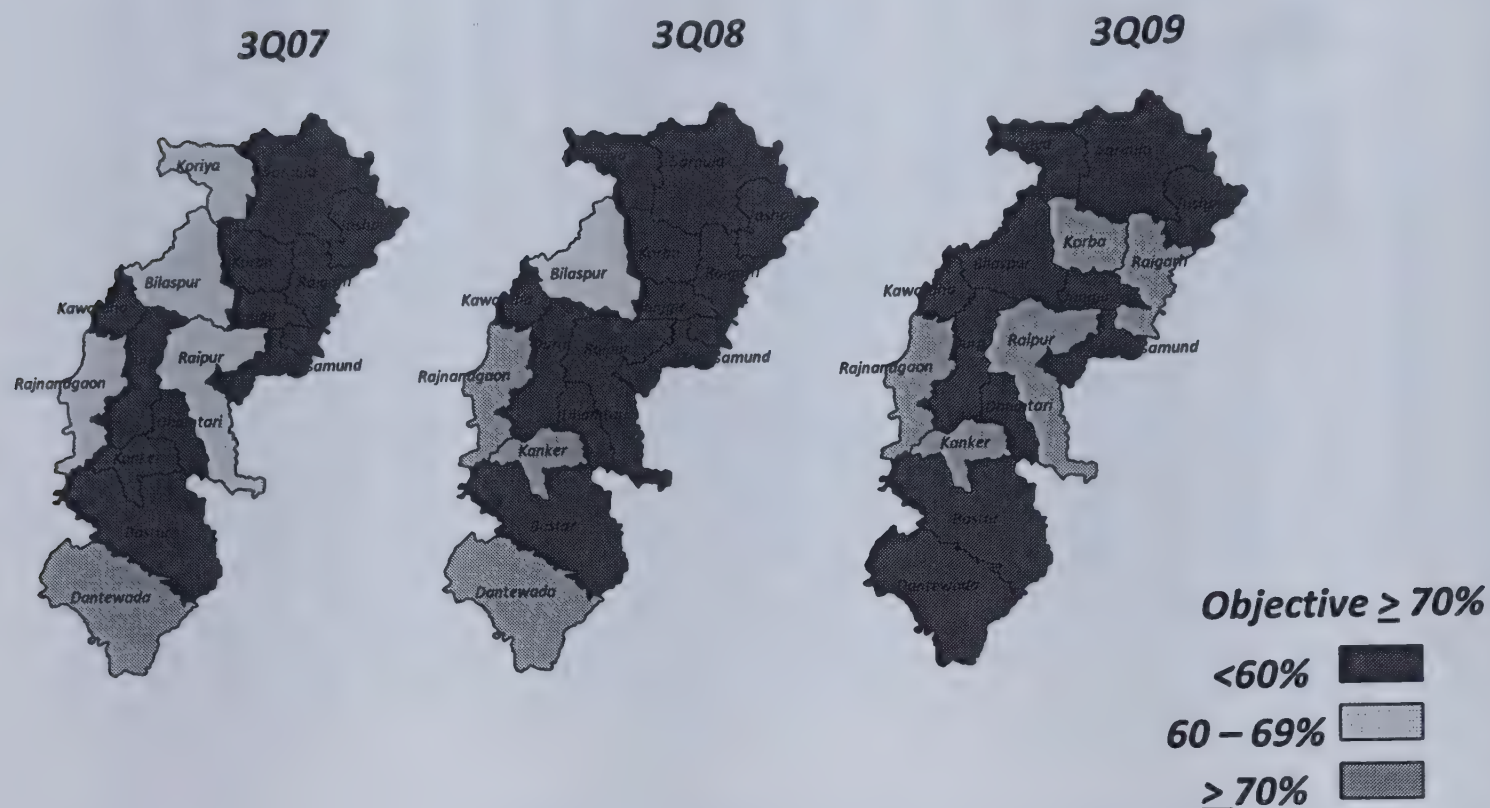
**Success Rate (%) of NSP patients registered in 4Q07 to 3Q08**



The thematic map below compares the new smear positive case detection rate for third quarters of previous three years. Districts Rajnandgaon, Kanker, Raipur, Korba and Raigarh have shown improvement in their performance for last three years and have achieved the objective of 70% case detection. The remaining districts are poor performing consistently.



### New Smear Positive Case Detection Rate



### District wise Target for year 2010-11.

District	Population 2001	Projected Population 2010	Expected total TB cases Annual	Expected NSP Cases Annual	Target Cases Detection Annual	Target Cases Detection Annual	Expected Referral Annual
Expected Cases/Lakh Population			216	80	151	56	560
Bastar	1198067	1403823	3032	1123	2120	786	7861
Narayanpur	108606	127258	275	102	192	71	713
Bilaspur	1998355	2341552	5058	1873	3536	1311	13113
Dantewada	478314	560460	1211	448	846	314	3139
Bijapur	241173	282592	610	226	427	158	1583
Dhamtari	706591	827941	1788	662	1250	464	4636
Durg	2810436	3293100	7113	2634	4973	1844	18441
Janjgir	1317431	1543687	3334	1235	2331	864	8645
Jashpur	743160	870790	1881	697	1315	488	4876



Kanker	650934	762725	1647	610	1152	427	4271
Kabirdham	584552	684943	1479	548	1034	384	3836
Korba	1011823	1185593	2561	948	1790	664	6639
Koriya	586327	687023	1484	550	1037	385	3847
Mahasamund	860257	1007998	2177	806	1522	564	5645
Raigarh	1265529	1482871	3203	1186	2239	830	8304
Raipur	3016930	3535058	7636	2828	5338	1980	19796
Rajnandgaon	1283224	1503605	3248	1203	2270	842	8420
Sarguja	1972094	2310781	4991	1849	3489	1294	12940
Chhattisgarh	20833803	24411800	52729	19529	36862	13671	136706

**Comparative performance in RNTCP in Case Detection (2008), Smear Conversion (4<sup>th</sup> Quarter 2007 to 3rd Quarter 2008), and Treatment Outcomes (2007) in WEST ZONE & states around CHHATTISGARH are shown in the following table:**

States → Activities ↓	Gujarat	M.H.	M.P.	C.G.	Jhar.	Orissa	A.P.	India
Suspects examined per lakh population Per quarter	168	140	108	115	114	133	155	149
% of Smear +ve cases among suspects	16%	13%	16%	12%	15%	14%	15%	13%
Annual total case detection rate per lakh	141	131	117	115	128	128	139	132
Annual new smear positive case detection rate per lakh and in (%)	63-78%	49-61%	43-54%	44-55%	56-75%	56-66%	61-81%	54-72%
% of new EP cases out of all new cases	18%	14%	22%	13%	9%	21%	13%	18%
% of smear positive retreatment cases out of	32%	23%	27%	12%	15%	16%	24%	24%



<i>all smear positive cases</i>								
<i>No. (%) of paediatric cases out of all New cases</i>	6%	6%	5%	6%	6%	6%	4%	6%
<i>Conversion rate of new smear positive patients</i>	92%	90%	88%	89%	90%	87%	92%	90%
<i>Cure rate of new smear positive patients</i>	87%	84%	82%	83%	83%	83%	86%	84%
<i>Success rate of new smear positive patients</i>	87%	86%	86%	87%	89%	87%	88%	87%

### **Stop TB Strategy**

The new WHO Stop TB Strategy, released in 2006, has identified six principal components to realize the global TB related Millennium Development Goals (MDGs) by 2015. They are:

- Pursuing high quality DOTS expansion and enhancement
- Addressing TB/HIV, MDR-TB and other challenges
- Contributing to health system strengthening
- Engaging all care providers
- Empowering patients and communities
- Enabling and promoting research

The state is committed to fully comply with the Stop TB Strategy in order to control TB until it ceases to be a major public health problem.

**Following were the activities done in the state to achieve the objectives of RNTCP:**

- Emphasizing at all levels of meetings and trainings for strengthening the quality of programme by ensuring timely referral, diagnosis by good quality microscopy and directly observed treatment.
- In order to strengthen the quality of microscopy at the district level, the Microbiologist & LT of Intermediate Reference Laboratory (IRL) have started the IRL visits to the districts. The IRL team reviewed the EQA activities of Korba & Janjgir districts.
- As the sputum microscopy is the back bone of programme & one of the components of DOTS, state has successfully established an Annual maintenance contract this year, to ensure quality microscopic activities at the field level.
- State and District level sensitization meetings with the BMO's, CMHO's, MOI/C's of the PHC and other paramedical staff's were conducted to ensure full participation of general health system.



- Update training on revised policy changes under RNTCP of all the health staff were conducted at state, district and block levels.
- Up-gradation of IRL is being done where minor civil works along with electrification of the building has been completed.
- Strengthening of TB/HIV coordination activities was one of the priority areas where regular trainings of staffs from both the programmes were planned and successfully completed.
- Most of the districts have given refresher training to the MPW's. Rural Medical Assistants (RMA's) in some of the districts are also trained in the programme. It planned to give 2 days' training at the district level to all the RMAs posted in the state. This will improve the referral of chest symptomatics for sputum examination.
- All the three medical colleges of the state are involved in the programme with fully functional DMC cum DOT centres. All the three colleges have the core committee to monitor the performance. The State Task Force is in place with Director Medical Education (DME) as the Chairman.
- To engage all health care providers in the programme a state level NGO workshop was organized which was attended by state & district level NGO's.
- The State has successfully utilized the services of health centres under Catholic Health Association of India (CHAI) network through various NGO schemes.
- Almost all the hospital under Public Sector Undertakings (PSU) like NTPC, BSP, SECL, BALCO, etc are involved in the programme by functioning either as a referral centre or as a Microscopy cum DOT centre.
- Efforts are continuously being to involve the Private Practitioners by conducting sensitization programmes of district level IMA bodies.

#### **Action Plan for achieving the goals & objectives of the programme for next year**

<b>S. No.</b>	<b>Priority area</b>	<b>Action plan under priority area</b>
1.	<b>Increasing NSP Case Detection</b>	<b>Increasing Identification and Referral of TB Suspects</b> <ul style="list-style-type: none"> <li>• Establishment of Sputum Collection Centres in Non-DMC PHI's. Incentive based services of MPW/ANM/Mitanins would be utilized for transportation of sputum samples from the collection centres to the DMC's.</li> <li>• Training of Rural Medical Assistant in identification &amp; referral of chest symptomatics to the nearest DMC.</li> <li>• Block level training of Mitandin/ANM/MPW for increasing the referral of chest symptomatics from the field.</li> </ul>



		<b>Ensuring Quality Assurance of Sputum Microscopy</b> <ul style="list-style-type: none"> <li>• Procurement of good quality reagents &amp; equipments as per guidelines.</li> <li>• Regular review of the EQA related records &amp; reports at the state level</li> <li>• Conducting IRL visits to the districts to further strengthen EQA activities and on job training to the LT's</li> <li>• State &amp; District level training of LT's are planned.</li> <li>• AMC of Binocular Microscope would be continued.</li> </ul>
2.	<b>Increasing the Cure Rate</b>	<ul style="list-style-type: none"> <li>• Emphasis on importance of regular follow-up while training various health care staffs.</li> <li>• Strengthening of Supervision &amp; Monitoring activities by STS/STLS, MOTC &amp; DTO</li> </ul>
3.	<b>Engaging all health care providers</b>	<ul style="list-style-type: none"> <li>• State level IMA Workshop is planned to further strengthen the involvement of Private Practitioners in the programme.</li> <li>• District level IMA sensitization workshops in all the districts are planned.</li> <li>• Involvement of Rotary Club would be the priority in the coming year.</li> <li>• Further strengthening the partnership with PSU hospitals in the state.</li> </ul>
4.	<b>Improving the involvement of Medical Colleges</b>	<ul style="list-style-type: none"> <li>• Organization of State level CME/Workshop</li> <li>• Training of all the faculty's / residents &amp; paramedical staff</li> <li>• Facilitate faculty/students in conducting OR/Thesis.</li> </ul>
5.	<b>Up-gradation of IRL for Sputum Culture &amp; DST</b>	<ul style="list-style-type: none"> <li>• Pending civil works required in the Intermediate Reference Laboratory (IRL) would be completed at the earliest.</li> <li>• Recruitment of STDC Staff is the priority of the state.</li> <li>• Up-gradation of IRL to establish Liquid Culture Facility.</li> </ul>
6.	<b>Initiation of DOTS Plus activities</b>	<ul style="list-style-type: none"> <li>• Formation of State DOTS Plus Committee</li> <li>• Identification of DOTS Plus Site &amp; its up-gradation for initiation of DOTS Plus activities.</li> </ul>
7.	<b>Strengthening of Supervision &amp; Monitoring activities.</b>	<ul style="list-style-type: none"> <li>• Intensify supervision at all levels in the state.</li> <li>• Regular State Internal Evaluations as per guidelines.</li> <li>• Conduct regular review meetings with the programme managers.</li> <li>• Block level monitoring of the district.</li> <li>• Training &amp; Re-training of MOTC, STS &amp; STLS at state level is</li> </ul>



		planned.
8.	<b>Strengthening TB/HIV Coordination</b>	<ul style="list-style-type: none"> <li>Revision of State Coordination Committee.</li> <li>Refresher training of all concerned staff on TB-HIV coordination.</li> <li>Linking Defaulter patients &amp; all Cat II patients with the nearest ICTC for counselling on regular follow-up &amp; adherence to treatment.</li> </ul>

**Priority Districts for Supervision and Monitoring by State during the next year:-**

S. No.	District	Reason for inclusion in priority list
1.	Bastar	Low cure / case detection rate. Separation of Narayanpur from Bastar
2.	Dantewada, Bijapur	Low cure / case detection rate. Separation of Bijapur from Dantewada
3.	Kawardha	Low cure / case detection rate. No contractual Staff under RNTCP
4.	Jashpur	Low cure / case detection rate. No contractual Staff under RNTCP
5.	Janjgir	Low Case detection
6.	Sarguja	Low Case detection
7.	Koriya	Low Case detection
8.	Raipur, Durg, Rajnandgaon & Bilaspur	Implementation of DOTS Plus services.

**Summary of Budget proposed under different heads for FY 2010-2011**

Budget Heads	Central TB Division	NRHM Flexi-pool	Total
Civil Works	44.64	34.12	78.76
Laboratory materials	39.55	0.00	39.55
Honorarium*	43.63	0.00	43.63
IEC/Publicity	49.76	20.00	69.67
Equipment maintenance	15.12	0.00	15.12
Training**	46.85	29.22	76.07



<b>Vehicle maintenance &amp; POL</b>	33.93	0.00	33.93
<b>Vehicle hiring</b>	52.24	0.00	52.24
<b>NGO/PP support</b>	76.23	0.00	76.23
<b>Miscellaneous</b>	39.39	0.00	39.39
<b>Contractual Services</b>	438.30	0.00	438.30
<b>Printing</b>	36.56	0.00	36.56
<b>Research and studies</b>	0	0.00	0.00
<b>Medical Colleges</b>	20.21	0.00	20.21
<b>Procurement-Vehicles</b>	1.0	6.00	7.00
<b>Procurement-equipment</b>	1.9	62.35	64.25
<b>Total</b>	<b>939.23</b>	<b>151.69</b>	<b>1090.92</b>
<b>Tribal activities</b>	73.32	0.00	73.32
	<b>1009.25</b>	<b>151.69</b>	<b>1160.94</b>
<b>Grand Total</b>	<b>1160.94</b>		

**\* 43.63 Lakh is amount required for FY 2010-11 and the amount required to clear pending honorarium from 2005 to 2009 would be submitted separately**

**\*\* In training head norms of CTD is 17.64 Lakh whereas the requirement is of 46.86 lakh**

**Justification for Budget required under civil works**

For Extension of existing State Drug Store = 13.0 Lakh

For Extension of existing 4 District Drug Stores = 21.12 Lakh

Total = 34.12 Lakh

**Justification for Budget required under procurement of equipments**

Digital Weighing Balance for 18 districts 18 x Rs 20,000 = 3.6

Water Bath each for a district 18 x Rs 30,000 = 5.4



Laptop & Pen-drive 50000 x 4 = 2.0
Almirah (Full size Big) - 1 for each DMC = 287, 2 for each TU = 124, 4 for each DTC = 72, 6 for STC = 6, Total 489 x Rs 10,500 = 51.35
<b>Justification for Budget required under procurement of Vehicles</b>
1 Four Wheeler for STDC

### Initiative Sanctioned under NRHM

#### Intermediate Level Reference Laboratory (IRL)

Chhattisgarh has established its own designated Intermediate level Reference Laboratory (IRL) in the State TB Training and Demonstration Centre (STDC) in Lalpur, Raipur. The IRL of Chhattisgarh is monitored by the Tuberculosis Research Centre, Chennai which is a National Reference Laboratory (NRL) and will undergo accreditation for sputum microscopy and mycobacterium culture and drug sensitivity testing by the NRL.

In the financial year 2010 – 2011 the state is committed to get accreditation for Culture and DST for its IRL and hence would facilitate the initiation of DOTS Plus activities. Following activities are planned on priority basis to achieve the same:

- Completion of pending civil works.
- Recruitment of STDC Staff.
- Up-gradation of IRL to establish Facility for Liquid Culture.

The detail of estimated budget is given below:

Budget Heads	Activity Planned	Central TB Division	NRHM pool	Flexi-
Civil Works	4 rooms for Line Probe Assay & Liquid Culture in IRL building (Renovation area = 520 sq.ft.@ 1000/sq.ft.)	0.00	5.20	
	Extension of STDC (2385 Sq. ft. @ 1200/sq.ft.)	0.00	30.00	
Procurement of Equipments	Negative Pressure System for 3 rooms for LPA & Liquid Culture	0.00	45.00	
	Air Curtain for IRL	0.00	1.25	



	Laminar Flow for IRL	0.00	3.50
	Water Coolers (40 L)	0.00	0.24
	Aqua-Guard Water Purification System	0.00	0.10
	Diesel for Generator (3 hrs/day x 12 L x Rs 36/L x 365 days)	0.00	5.00
	Almirah (Full size Big) - 10 in No.s @ 10,500 each	0.00	1.05
	LCD Projector for STDC/IRL	0.00	1.00
<b>Contractual Services</b>	Salary for One Sr. LT @ 15000 pm (15000 x 12)	1.80	0.00
	Salary for 4 LT from NRHM @ 8500 pm (8500 x 12 x 4)	0.00	4.08
	One Data Entry Operator @ 10000 pm (10000 x 12)	1.20	0.00
	One Asstt Programme Officer @ 40,000 pm (40000 x 12)	4.80	0.00
	One Driver @ 7000 pm (7000 x 12)	0.00	0.84
	2 Sweepers @ 3500 pm (3500 x 12 x 2)	0.00	0.84
<b>Total</b>		<b>7.80</b>	<b>98.10</b>
<b>Grand Total</b>			<b>105.90</b>

### **Multi-Drug Resistance TB (MDR-TB) and DOTS Plus**

The emergence of resistance to drugs used to treat tuberculosis (TB), and particularly multi-drug resistant TB (MDR-TB), has become a significant public health problem and an obstacle to effective TB control. Traditionally, DOTS-Plus refers to DOTS programmes that add components for MDR-TB diagnosis, management and treatment.



Available data from the earlier district-wise and now state representative surveys in Gujarat and Maharashtra have found ~3% MDR-TB among new cases and 12–17% among cases with a previous history of anti-TB treatment.

The treatment of MDR-TB cases will follow the internationally recommended DOTS-Plus guidelines and will be done in designated RNTCP DOTS-Plus sites. These sites will be in highly specialized centre’s (e.g. Medical College hospitals, Chest and respiratory disease institutes etc.) which will have ready access to an RNTCP accredited culture and DST laboratory, with qualified staff available to manage patients using standardized second-line drug regimens given under daily DOT and standardized follow-up protocols, have systems in place for an initial short period of in-patient care to stabilize the patient on the second-line drug regimen followed by ambulatory DOT and with a logistics system and standardized information system in place.

The Chhattisgarh state has planned to initiate the DOTS Plus activities in the year 2010. A State DOTS Plus Committee would be constituted which will identify appropriate DOTS Plus Site in the state and the districts to be covered in the first phase of DOTS Plus.

The budget proposed for FY 2010 - 2011 for initiation of DOTS Plus activities in the state is give below:

Budget Heads	Activity Planned	Central TB Division	NRHM Flexi-pool
Civil Works	DOTS Plus Ward 30 bedded	10.00	138.00
Procurement of Equipments	Generator for DOTS Plus Site 20 KV	0.00	3.50
	Water Coolers (40 L)	0.00	0.24
	Aqua-Guard Water Purification System	0.00	0.10
	Diesel for Generator (3 hrs/day x 12 L x Rs 36/L x 365 days)	0.00	5.00
	Almirah (Full size Big) - 4 in No.s @ 10,500 each	0.00	0.42
	Computer, Fax, Printer, Photocopier & other peripherals for DOTS plus site	0.00	1.65
Honorarium/ Financial Support	Travel cost for a patient & one attendant (minimum 50 patients in a year) Rs 500 to & fro	0.00	0.25



	Cost of treatment of adverse effect & investigation for a patient (minimum 50 patients in a year) Rs 20000 per patient	0.00	10.00
<b>Contractual Services</b>	One DOTS Plus Site Sr. MO @ 30000 pm (30000 x 12)	3.60	0.00
	2 MO @ 30000 pm (30000 x 12 x 2)	0.00	7.20
	One DOTS Plus Site Statistical Assistant @ 15000 pm (15000 x 12)	1.80	0.00
	Four Senior DOTS Plus Supervisor one each for districts Raipur, Durg, Rajnandgaon & Bilaspur @ 15000 pm (15000 x 12 x 4)	7.20	0.00
	4 Staff Nurse @ 9760 pm (9760 x 12 x 4)	0.00	4.69
	1 Pharmacist @ 8662 pm (8662 x 12)	0.00	1.04
	2 Ward Boy & 2 Aya @ 3500 (3500 x 12 x 4)	0.00	1.68
	1 Sweeper @ 3500 (3500 x 12)	0.00	0.42
<b>Total</b>		<b>22.60</b>	<b>174.19</b>
<b>Grand Total</b>			<b>196.79</b>

**Consolidated Summary of Budget Proposed for FY 2010 – 2011 (in Lakh)**

	<b>Central TB Division</b>	<b>NRHM Flexi-pool</b>	<b>Total</b>
District & State Consolidated	1009.25	151.69	1160.94
Up-gradation of IRL	7.8	98.1	105.9
DOTS Plus Site	22.6	174.19	196.79
<b>Total</b>	<b>1039.65</b>	<b>423.98</b>	<b>1463.63</b>



## J. Non-Communicable Diseases

### J.1 National Cancer Control Programme (NCCP)

#### Proposal

The proposed schemes for NCCP in 11<sup>th</sup> five year plan are as follow

- (i) Financial incentive schemes for early detection of cases of PHE / CHE Level.
- (ii) Up gradation of CHC- early detection & referral
- (iii) Basic cancer care services of District Hospital. 5 District Hospital (Level-I without radiotherapy and 1 District hospital (Level-II with radiotherapy)
- (iv) Tertiary level cover Care ( Level III Oncology wing) and ( level IV Regional Cancer Centre schemes )
- (v) Miscellaneous:
  - a. Training
  - b. IEC
  - c. Cancer Research including Vaccine research.
  - d. National Cancer Institute.
  - e. National Cancer Fund
  - f. Monitoring Cell at State

#### Objectives of NCCP for 11<sup>th</sup> Plan

1. Primary prevention of cancer by health education & promotion of health life style for prevention cancer.
2. Secondary prevention I.E. early detection & diagnosis of cancer of cervix, breast & oropharynx up to community health centre.
3. Establishment of baseline care facilities for surgery, radiotherapy & Chemotherapy at District Hospital.
4. Providing palliative & rehabilitative care in advance stage of cancer.



5. Training of doctors, physicians & nurses.
6. Strengthening / establishing specialized cancer management units at tertiary level Hospital.

### Proposal 11<sup>th</sup> five year plan

#### Financial Proposal

##### (1) Financial Incentive

An incentive of Rs. 300/- confirmed case would be given to health functionaries ( Doctors, Health Workers, Health Assistants, & Mitnin at the level of CHC & PHC. Any suspected cases of cancer will be referred by Mitnin or health worker / assistant to CHC / PHC Doctors along with referral slip with complaints & signs & symptoms written on it.

The doctor at CHC / PHC will examine & investigate as per available facilities or refer these cases for confirmation of diagnosis. For each confirmed case ground level worker will be given Rs. 100/- & Doctor would be given Rs. 200/-.

In a year about 100 cases are about to be detected in 1, 00,000 population. In one PHC there could be about 25 cases of estimated new cancer per year. Some patients may directly go to CHC or Other higher centre. So the incentive would be for an estimated 15 confirmed cancer cases per year per PHC @ 300/-/ case. In first year it is assumed that cases may be doubled that in 30 cases.

Incentive Rs. 300/- / case / year / PHC (population of 1 lakh) / for worker X 30 cases / year / PHC = Rs. 9000/- / PHC / year.

Physical target for C.G. State in year 2010-11 is 21 PHC. So, financial incentive load may be Rs. 9000 / PHC X 21 PHC = Rs. 1, 89,000.

Table: I Incentive for Health Personnel at PHC level

Sl .No.	Incentive	Cases	PHC	Total amount
1	Rs. 300 / case	30 cases	21	<b>Rs. 1,89,000</b>

The doctors of CHC will also be given incentive @ 300/- confirmed case subject to maximum 40 cases. In first year there may be doubled case detected, but incentive may be restricted to 40 cases @ 300/- maximum to 12000/-. The total financial level for 5 CHC may be 12000 X 5 = Rs. 60,000/-.

Table: II Incentive for Doctors of CHC.



Incentive	Case	CHC	Total amount
Rs. 300/-	40	5	Rs.60,000/-

**Up gradation of CHC**

**Early detection & referral (level-O)**

In 1, 00,000 population of CHC there may be 300 cover cases. About 80-120 new cancer are likely every year (10 new cases / month) . So there should be facilitated for early detection, referral are to be made available for cover patients at CHC level. Each CHC should have physician, surgeon, Gynaecologist & paediatrician & some contractual staff under NRHM.

There are many type of cancer which could be detected plainly by clinical examination & preliminary investigation. There could be provision of visiting cancer physician / surgeon with remuneration of Rs. 2500 / visit.

Few of the diagnostic facilities like mammography, biochemical pathological, micro biology tumour test can be made available by PPP model. The non recurring amount is Rs. 10000/- & recurring expenditure is Rs. 7.2 Lacks / year /CHC.  $Rs. 7,20,000 + 10,000 = Rs. 7,30,000 \times 5$  CHC = Rs. 36,50,000/- is regulated for 5 CHC.

**Table: III Non-Recurring Expenses**

Article	Expenditure	CHC	Total Amount
Megna Visualiser Equipment (VIA)	RTs. 10000	5	Rs. 50,000/-
-Indirect Laryngoscope			
-Punch Biopsy forceps			

**Recurring Expenditure / Year**

Article	Expenditure (Lacks)	CHC	Total Amount (Lacks)
Manpower	4.8	5	Rs. 24.0
P.P.P for investigation	1.2	5	Rs. 6.0
consumable	1.2	5	Rs. 6.0
TOTAL	7.2 Lacks		36.0 Lacks



### Manpower for CHC

Man power	Remuneration	Duration	Total Amount
Part time cancer surgeon @ 2500/visit/ twice a week	Rs. 2500	104 weeks	Rs. 2,60,000
Nurse	Rs. 500 / Week	104 weeks	2,60,000
<b>TOTAL</b>			<b>Rs. 5,20,000</b>

**Basic cancer care centre level-I (Without radiotherapy).**

### Early detection & basic Cancer Care.

1. Under PPP model laboratory test which are not available in district will be made available. The financial load will be for one district in Rs. 2.4 LACKS / YEAR.
2. Home based palliative care team and comprising of Doctor + Nurse + Mitanin. Mitanin will be provided incentive of Rs. 300/- /month/cancer patient.

Total financial load may be Rs. 300/- X 30 Cases / PHC X 21PHC =Rs.1, 89,000.

### 3. Consumable

Table: IV Expenditure for Consumables

Article	Expenses	Months	Total Amount
Gloves, Swab, Glacial Acetic Acid, D.W, Rubber / plastic sheet, Specimen Bottle, Disposable , Tongue Depressor	Rs. 10,000 / Month	12 Months	<b>Rs. 1,20,000/-</b>

### Up gradation of District Hospital

#### Non Recurring Expenditure

1. Establishment District Cancer cell and Equipment
2. Machine & Equipment for diagnosis budget allocation Rs. 34,25,000 / District.

#### Recurring Expenditure

1. For payment of contractual staff.
2. Provision of making available of diagnosis facilities & doctors under PPP model.



Budget allocation Rs. 31,00,000/- / District for 1 district in CG.

**IEC activities:**

Rs. 1,00,000 for one district for display board in 21 PHC, 5 CHC & 100 Sub-Centres.

**Non Recurring Expenses 1<sup>st</sup> year**

Sl. No.	Description	Rs. In Lacks
1	District lances cell (renovation / office equipment / Fax / Phone / Computer / Photo copy machine	Rs. 5 Lacks
2	Mammography machine: Rs. 25 lacks Colposcope : Rs. 4 lacks Cryoprobe : Rs. .25 lacks	Rs. 29.25 lacks
TOTAL		Rs. 34.25 lacks

**Recurring Expenses**

Sl. No.	Description	Rs. In Lacks
1	Manpower	8.6
2	Chemo therapy drugs @ Rs. 50000 / PM	6
3	Lab Expenses @ Rs. 10000/ PM	1.2
4	Palliation care @ Rs. 1000 / PM	1.2
5	IEC	1
6	Misc. Office / Advance expenditure @ Rs. 500 / PM	0.60
7	PPP for lab investigation	2.4
	TOTAL	31.0

**TOTAL FINANCIAL LOAD**

Sl. No.	Summary of Expenditure	Amount (Rs.)
1	Incentives PHC: Rs. 1,89,000/- CHC: Rs. 60,000/-	Rs. 2,49,000
2	Up gradation of CHC to NRE : Rs. 50,000/- RE : Rs. 36,00,000/-	Rs. 36,50,000
3	Home base palliative Care	Rs. 1,89,000
4	Man power for CHC	Rs. 5,20,000
4	Expenses for consumable at CHC	Rs. 1,20,000
5	Up gradation of District Hospital - NRE : Rs. 34,25,000/- - RE: Rs. 31,00,000/-	Rs. 65,25,000
	GRANT TOTAL	Rs. 1,12,53,000



## J.2 National Tobacco Control Programme

*Proposed Activities for Programme in Districts :*

- 1- Monitoring & implementation of Anti Tobacco laws.
- 2- IEC/Mass Media Campaign
- 3- School Health Programme
- 4- Training & Capacity building
- 5- Tobacco cessation Centre

*In year 2010-11 two District will be taken up for the pilot project for NTCP. These Districts will be*

1. Raipur
2. Bilaspur

### 1- Monitoring & Implementation

*Activity Should be encouraged to aware about the law to the different groups of society such as women SHG, NGO, ULB, PRI School teachers, health workers & law enforcers. It would be key to sustainable action for effective implementation of Act. At grass root level.*

- 2- IEC & mass media campaign can be worked out with specific district level intervention.
- 3- School Health Programme is aimed at creating awareness amongst school children & teachers regarding act.
- 4- Training & Capacity Programme will target the school teachers, Health workers law enforcers, WSHG & other civil society organization etc.
- 6- Developing dist- T.C.C. under supervision of Medical Officer.

*Proposed Budget for DTCP (2010-2011)*

Sl. No.	Components	Calculation INR	Total INR
I.	Salaries 1. psychologist: Rs. 10,000/- 2. Social Worker : Rs. 8,000/-	10000 x 12 8000 x 12	216,000.00
II.	Training	200,000.00	200,000.00



III.	IEC activity	200,000.00	200,000.00
IV.	School Activity	400,000.00	400,000.00
V.	Monitoring of Tobacco Control Laws & Reporting	100,000.00	100,000.00
VI.	Contingency	100,000.00	100,000.00
VII.	TOTAL		1,216,000.00

### Proposed Activities for State Tobacco Control Programme

The state tobacco control all will effectively Coordinate/ Monitor the proposed initiatives under the district tobacco control programme. The establishment of state T.C.C. will facilitate of D.T.C.C. Nodal Officer of State level & state Programme manager NRHM will responsible for overall coordination Monitoring & evaluation T.C.C. will be established at a cost of Rs. 6-92 lakh & supported by programme Assistant five for IEC Activities, Training Monitoring.

### Proposed budget for state Tobacco control cell 2010-2011

Sl. No.	Components	Calculation INR	Total INR
I.	Salaries 1. Programme Assistant: Rs. 10,000/- 2. Data Entry Officer : Rs. 6000/-	10000 x 12 6000 x 12	192,000.00
II.	Training	100,000.00	100,000.00
III.	IEC activity	300,000.00	300,000.00
IV.	Contingency	100,000.00	100,000.00
VI.	Contingency	100,000.00	100,000.00
VII.	TOTAL		692,000.00

The total budgetary support required is an below

state level cell :	Rs. 692000=00
2 district level cell :	Rs. 1216000=00
Total	Rs. 1908000=00

### J.3 National Programme for Prevention & Control of Diabetes, Cardiovascular disease & stroke (PNDCS)

India is experiencing a rapid transition in life style and behavioural change, favouring onset of choric diseases. As per the statistic, 53 % of all the deaths and 44 % of DALYs lost in a year 2005 which is a serious public health concern in a county. Considering the disease burden, Diabetes Mellitus, Cardiovascular Disease, Cancer, and stroke are the major contributing element in the NCD. In the past, India has taken enormous steps to avoid epidemic of



communicable disease and somehow we have succeed, but still need some serious efforts to take for non communicable disease in upcoming years.

At the present stage, India contributes substantially to the global burden of NCDs. In 1990, India accounted for 19 per cent of all deaths, 16 per cent of all NCD deaths, and 17 per cent of all CVD deaths in the world. CVDs in India alone accounted for around 2.4 million deaths annually.

The program for non communicable disease started in 1975-76, with priority for equipping the premier cancer hospitals and revised in 1984-86 to early detection and treatment of cancer cases. With this all background, in 11<sup>th</sup> year plan, strategy has revised to make this program population based interventions, addressing multiple risk factors by implementing at the level of CHC and PHC level. For which revised objective and strategies have been formulated such has

1. To assess the prevalence of risk factors for Non- Communicable Diseases
2. Risk reduction for prevention of NCDs (Diabetes, CVD and Stroke)
3. Early diagnosis and appropriate management of Diabetes, Cardiovascular Diseases and Stroke

### **Strategies**

1. Surveillance of risk factors of Non-Communicable Diseases.
2. Health Promotion for the General Population
3. Disease Prevention for the High Risk groups

Since we have no clear statistic to show the prevalence and incidence at local level, emphasis will given to find distribution of risk factors for Non-Communicable Diseases especially Diabetes, CVD and Stroke-through repeated surveys in the population will include which may include Demographic and socio-economic characteristics, addiction , Physical activity, Dietary patterns or Blood pressure etc.

### **Key issues to be addressed**

1. Healthy food habits
2. Control of Overweight and Obesity
3. Regular physical activity
4. Avoidance of tobacco and alcohol
5. Stress management
6. Control of Blood Pressure, Blood Sugar and Blood Cholesterol/Lipids



## (ii). Setting up special clinics

1. Special clinics for Diabetes / Cardiovascular disease / Stroke in District Hospitals
2. To screen high risk individuals
3. To Provide management
4. Based on standard treatment guidelines
5. To refer to higher centres

## (iii). Harnessing the Private Sector

1. To replace high cost, low yield technologies with cost effective interventions
2. To initiate structured Continuous Medical Education programmes

## (iv). Intervention at tertiary level

1. Identification of referral centres
2. Strengthening of the centre through provision of necessary infrastructure
3. Strengthening the linkage to the nearest District hospital and health systems

## Expected outcomes for the pilot phase

1. Population distribution of NCD risk factors made available
2. Awareness generated on healthy life style
3. Health promotion at School , Community & Work places
4. Health system capacity building for prevention and control of NCDs
5. Methodology and approaches finalized for Nationwide implementation

### Physical Target

1. District Identified – 02
2. CHCs- 09
3. PHCs- 50
4. Mitanin - 500
5. Medical college 00

### Budget estimation

District	CHC fund	PHC Fund	Medical College	State NCD cell	Mitanin	Urban Initiative	Total
5396000	900000	2500000	0	1134000	1050000	560000	11540000

The requested budget form the NRHM for the year 2010-11 is Rs. 11540000



## PART - K : Convergence

### K. CONVERGENCE

#### Introduction:

The Health department will have convergence in action in the State for achievement of NRHM goals with various departments like Women and Child Development, Education, Rural Development and Panchayati Raj, Social Welfare etc.

#### Current Status

Some of the salient areas of convergence in the current year have been:

- Convergence with Tribal Welfare Department for development of career pathways for tribal community health volunteers to become Nurses and ANMs. It will also help in bridging the human resource gap in tribal areas.
- Convergence with Panchayats, Rural Development department, Women & Child Development department esp. NREGS, Public Health Engineering Department through initiatives of Swasth Panchayat Yojana and Village Health and Sanitation Committees. A large number of Panchayat Representatives were also trained in village health planning. Training modules were developed in consultation with Rural Development department. 3000 Village health plans were operationalised through grassroots convergence between ASHA, Anganwadi workers, PRI representatives etc.
- Convergence with ICDS for capacity building of grassroots workers like Anganwadi workers on areas of IMNCI Training, Nutrition Counselling and Development of BCC kit.
- As noted by Common Review Mission of NRHM, Chhattisgarh has established a strong process of Village Health and Nutrition Day in which three frontline workers i.e. ASHA, ANM and Anganwadi workers are collaborating very well.

#### Focus Areas for 2010-11:

- Village Health and Nutrition Day
- Village Health Planning and Swasth Panchayat Initiative will deepen its impact on joint decentralised planning with active involvement and capacity building of PRIs.



- *ASHA and Anganwadi Worker convergence through training on BCC through a common module*
- *Referral of severely malnourished children to Health facilities through Anganwadi and their follow-up at community level*
- *AYUSH orientation for Anganwadi workers as done for Mitans earlier*
- *Home Based Neo-natal Care would also involve convergence between the trained workers i.e. ASHA and Anganwadi worker along with ANM.*
- *School Health Programme*

#### **Budget Requirements:**

*The other initiative shall continue with available resources under different capacity building programmes.*



**Budget Summary**

<b>National Rural Health Mission, Chhattisgarh</b>		
<b>Project Implementation Plan 2010 - 10</b>		
	<b>PART -A</b>	
<b>A.1</b>	<b>MATERNAL HEALTH: Operationalise facilities (only dissemination, monitoring, and quality)</b>	
<b>A.1.1</b>	<b>Operationalise facilities (Only dissemination, monitoring and quality)</b>	
<b>A.1.1.1</b>	<b>Operationalise FRUs</b>	<b>0.00</b>
<b>A.1.1.1</b>	<b>Blood Storage Facility:</b>	<b>0.00</b>
<b>.1</b>		
<b>A.1.1.1</b>	<b>Indemnity Insurance for the Multi Skilled MOs</b>	<b>7.50</b>
<b>.2</b>		
<b>A.1.1.2</b>	<b>Operationalise 24x7 PHCs</b>	<b>311.04</b>
<b>A.1.1.3</b>	<b>MTP services at health facilities</b>	<b>0.00</b>
<b>A.1.1.4</b>	<b>RTI/STI services at health facilities</b>	<b>0.00</b>
<b>A.1.2</b>	<b>Referral Transport Linkages</b>	<b>25.00</b>
<b>A.1.3</b>	<b>Integrated outreach RCH services / Camps</b>	<b>7.15</b>
<b>A.1.3.1</b>	<b>Monthly Village Health and Nutrition Days</b>	<b>0.00</b>
<b>A.1.4</b>	<b>Janani Suraksha Yojana / JSY</b>	<b>7467.20</b>
<b>A.1.4.1</b>	<b>Incentivisation for institutional delivery</b>	<b>80.65</b>
<b>A.1.5</b>	<b>JSY Call Centre</b>	<b>45.92</b>
<b>A.1.6</b>	<b>Maternal and infant death auditing committee:</b>	<b>7.60</b>
	<b>Sub Total</b>	<b>7952.06</b>
<b>A.2</b>	<b>Child Health</b>	
<b>A.2.1</b>	<b>IMNCI: Integrated Management of Neonatal and Childhood Illnesses</b>	<b>0.00</b>
<b>A.2.2</b>	<b>Facility Based Newborn Care/FBNC</b>	<b>228.10</b>
<b>A.2.3</b>	<b>Home Based Newborn Care/HBNC in Chhattisgarh</b>	<b>258.58</b>
<b>A.2.4</b>	<b>School Health Programme: "Swasth Pathshala Yojana"</b>	<b>86.50</b>
<b>A.2.5</b>	<b>Care of Sick Children and Severe Malnutrition</b>	<b>50.00</b>
<b>A.2.6</b>	<b>Management of Diarrhoea, ARI and Micronutrient Malnutrition</b>	<b>0.00</b>
<b>A.2.7</b>	<b>Navajat Sishu Suraksha Yojana (NSSK)</b>	<b>716.32</b>
<b>A.2.8</b>	<b>Other strategies/activities</b>	<b>0.00</b>
<b>A.2.8.1</b>	<b>Child Friendly Health Facility Accreditation:</b>	<b>15.17</b>
<b>A.2.8.2</b>	<b>Swagath Package for Mothers and Newborns for institutional deliveries (A package of services for mothers and newborns)</b>	<b>0.00</b>
<b>A.2.8.3</b>	<b>Integrated bi – annual maternal and child health month (Sishu Sanrakshaan Maah)</b>	<b>813.88</b>
	<b>Sub Total</b>	<b>2168.55</b>
<b>A.3</b>	<b>FAMILY PLANNING</b>	



	Wages compensation for Female Sterilization beneficiaries- Public	1600.00
	Wages compensation for Female Sterilization beneficiaries- Private	300.00
	Wages Compensation for Male Sterilization beneficiaries	300.00
	NSV Camp	0.00
	IUD incentive beneficiary - Public	25.00
	IUD incentive beneficiary - Private	11.25
	Annual maintenance of laparoscopic machine in the district where machine and surgeons are available	22.00
	Maintenances of OT	1.80
	Incentive for Fixed day services	60.00
	Procurement of NSV Kit	10.00
	laparoscope	200.00
	<b>Grant Total</b>	<b>2530.05</b>
A.4	Adolescent Reproductive and Sexual Health / ARSH	10.00
A.5	Vulnerable Groups: Particularly Vulnerable Tribal Groups (PTGs)	
	Social Mobilisation of PTG Mitanins	1.50
	Coverage of all PTG families under RSBY	160.00
	Special Camps in PTG clusters	5.00
	<b>TOTAL</b>	<b>176.50</b>
A.6	Innovations/ PPP/ NGO	0.00
A.7	Infrastructure & Human Resources	
A.7.1	Contractual Staff & Services	
A.7.1.1	ANMs: Appointment of ANMs:	74.40
A.7.1.2	Major civil works for operationalisation of 24 hour services at PHCs	
A.7.1.2.1	Renovation of labour room in PHC	766.50
A.8	Implementation of PNDT Act:-	5.00
A.10	INSTITUTIONAL STRENGTHENING	
A.10.1	Human Resources Development	0.00
A.10.2	Logistics management/ improvement	0.00
A.10.3	Monitoring & Evaluation / HMIS	0.00
A.10.4	Sub Centre Rent and Contingencies	0.00
A.11	TRAINING	
A.11.1	Strengthening of Training Institutions	0.00
A.11.2	Maternal Health Training	
A.11.2.1	Skilled Birth Attendance / SBA	146.88
A.11.2.2	BEmOC Training	30.86
A.11.2.3	EmOC Training	55.74
A.11.2.4	Life saving Anaesthesia skills training	25.49
A.11.2.5	MTP training	34.70
A.11.2.6	RTI / STI Training	0.00



A.11.2.7	Other MH Training (ISD Refresher): Staff Nurse Induction Training	52.62
A.11.4	IMEP Training	16.50
A.11.5	Child Health Training	
A.11.5.1	IMNCI: Facility based - Integrated Management of Neonatal and Childhood Illnesses	53.11
A.11.5.2	Facility Based Newborn Care	0.00
A.11.5.3	Home Based Newborn Care	0.00
A.11.5.4	Care of Sick Children and severe malnutrition	0.00
A.11.5.5	Training under Navajati Sishu Suraksha Karyakram	77.62
A.11.6	Family Planning Training	
A.11.6.1	Laparoscopic Sterilisation Training	8.03
A.11.6.2	Minilap Training	10.04
A.11.6.3	NSV Training	3.81
A.11.6.4	IUD Insertion Training	0.00
A.11.8	Programme Management Training	
A.11.8.1	SPMU Training	8.00
A.11.8.2	DPMU & BPMU Training	15.91
A.11.9	Other training	0.00
A.12	BCC / IEC: Proposed Activities and Budget	148.00
A.13	PROCUREMENT	1000.00
A.13.1	Procurement of Equipment	
A.13.1.1	Procurement of equipment: MH	
A.13.1.2	Procurement of equipment: CH	
A.13.1.3	Procurement of equipment: FP	
A.13.1.4	Procurement of equipment: IMEP	
A.13.2	Procurement of Drugs and supplies	
A.13.2.1	Drugs & supplies for MH	
A.13.2.2	Drugs & supplies for CH	
A.13.2.3	Drugs & supplies for FP	
A.13.2.4	Supplies for IMEP	
A.13.2.5	General drugs & supplies for health facilities	
A.14	PROGRAMME MANAGEMENT	
A.14.2	Strengthening of Financial Management systems	
A.14.3	Other activities (Prog. Management Expenses, Mobility support to state, district, block for all staff).	
Total		2533.21
	<b>Grant Total Part A</b>	<b>15360.37</b>
	<b>PART -B</b>	
	<b>TIME LINE ACTIVITIES-ADDITIONALITIES UNDER NRHM MISSION FLEXIPOOL.</b>	
B1	Strengthening Mitani Programme	



	Training and regular support for the strengthening of 60,000 Mitanins	2007.70
	Mitanin Dawa Peti distribution	26.28
	Programme Management and Coordination	227.76
	Allocation From ASHA budget under NRHM( For Mitanin Drugs one refill every two month of Rs 75 for each Mitanin- in addition to the allocation available with state budget- to fill gaps of chloroquine etc))	270.00
	Mitanin Help Desk	
	District (Recurring cost Per month@4200 per district)	6.80
	Block-CHC ( Recurring cost Per month@2400 per block)	31.54
	Jeevan Deep Samiti	1029.00
	Maintenance grants for SHCs, PHCs and CHCs	601.00
	ISO Certification	
	Untied fund for PHC/CHC/SHC/CS/CH	744.10
	Untied fund for VHSC/	1927.60
B.3.1	VHSC Sammelans:	15.50
B.4	Hospital Strengthening	
B4.1	DISTRICT HOSPITAL PLAN	600.00
B4.2	ISO Certification	325.00
B5	New Constructions/ Renovation and Setting up	
B5.1	Closing Residential Gap	2500.00
B5.2	SHCs/Sub Centres	1804.00
B7	District Innovation	1200.00
B.8	Special initiative: Establishment of Snakebite Case Management Unit in district hospital	3.00
B.8.1	Chhattisgarh Rural Medical Corps	827.45
B.8.2	Strengthening the role of Panchayati Raj Institutions in Health	60.53
B.8.3	Mainstreaming of AYUSH	
	AYUSH Health Melas at District and Block Level	97.20
	Flexible untied fund for AYUSH Deep Samiti as mobility support	17.16
	Contractual Appointment of AYUSH Medical Officers in the underserved areas in phase manner	90.00
	Infrastructural Development of Labour Ward Facilities at the selected dispensaries	35.00
	Yoga Popularization in Ayurved Gram	1.08
		17.52
	AYUSH Deep Samiti	176.00
	AYUSH Programme Assistant	21.60
	Exchange programme by External Experts and Consultants for Ayurveda medical Officers	4.80
	Prevention of disability in leprosy cured persons through Homeopathic Medicine	44.82



	National Consultative Workshop for creation of roadmap for mainstreaming	0.00
	AYUSH Technical Assistance	0.00
	AYUSH Training for Anganwadi Workers	0.00
	Additional Manpower for tribal CHC/PHC	0.00
	SICKLE CELL ANEMIA	50.42
B9	IEC-BCC NRHM	
B9.1	Health Mela	46.72
	Mobile Medical Unit	0.00
B12	Additional Contractual Staff (Selection, Training, Remuneration)	
B12.4	RMA: Utilising the 3-Year Rural Medical Training Assistant	1548.00
B.13	PPP/ NGOs	
B13.1	Non-governmental providers of health care RMPs/TBAs in Aid to NGOs	
B.14	Training	
B14.3.3	PHRN: capacity building in public health management of state, district and block	34.65
B14.3.4	Career Development pathway for Health Staff (ANMs) and Mitanins	241.75
B.16	Incentives Schemes	
B.17	Planning, Implementation and Monitoring	
B.17.1	Community Monitoring (Visioning workshops at state, Dist, Block level)	18.13
B.19	Monitoring and Evaluation / HMIS	266.60
B.19	Procurements of Drug, Machinery, and Equipment	1000.00
B22	New Initiatives/ Strategic Interventions (As per State health policy)/ Innovation/ Projects (Telemedicine, Hepatitis, Mental Health, Nutrition Programme for Pregnant Women, Neonatal) NRHM Helpline) as per need (Block/ District Action Plans)	
B.22.1	Establishment of Chhattisgarh Medical Services Corporation (CGMSC)	7.15
		646.00
	Chhattisgarh Health Equipment Management Cell	118.94
	Proposal for Emergency Response Medical Services in Chhattisgarh	1025.00
	New Initiatives for Mitanin	384.00
	Parenteral Iron therapy	225.00
	Janani Suraksha Kit	80.00
	Nutritional Support to PLHAs in Chhattisgarh State	4.25
	Mental Health Program	
	1. Construction of building	200.00
	Construction of staff quarters	200.00
	Constructing of boundary wall	70.00
	Construction of water tank	50.00
	Transit care home	45.60
B.25	State Health Resources Centre (SHRC)	50.00



B.25.1	Strengthening Human Resources in Health Sector: SHRC Contribution	5.00
B26	Support Services	
B26.1	Support Strengthening NPCB	
B26.2	Support Strengthening Midwifery Services under medical services	
B26.3	Support Strengthening RNTCP	
B26.4	Contingency support to Govt. dispensaries	
B26.5	Other Support Programmes (Snakebite)	
B27	NRHM Management Costs/ Contingencies	
	Strengthening of Programme Management Support Unit	
	Strengthening State PMU & NRHM Secretariat	150.40
	Strengthening District PMU	123.38
	Strengthening Block PMU	450.74
	Bal Hruday Raksha Yojana: Chief Ministers' Child Heart Protection Scheme	500.00
	Cochlear Implant for Children with Hearing Difficulty	100.00
	Telephone connection in Sub Health Centre/ PHS/CHC and District hospital	0.00
	Mobile medical Unit	0.00
	Integrated outreach camps in difficult areas	
	<b>Total Part B</b>	<b>22354.17</b>
	<b>Part- C</b>	
	Immunisation Strengthening programme	
	Mobility support for supervision	9.00
	Supervisory visits by state and district level officers for monitoring and supervision of RI	1.00
	Cold Chain maintenance	6.09
	Focus on slum & underserved areas in urban areas:	66.00
	Mobilization of children through ASHA/mobilizers	360.00
	Alternative Vaccine Delivery:	
	NE States, Hilly terrains and geographically hard to reach areas e.g. Session site>30 kms from vaccine delivery point, river crossing etc.	7.56
	For RI session in other areas	119.70
	Support for Computer Assistant for RI reporting (with annual increment of 10%)	20.45
	Printing and dissemination of immunization cards, tally sheets, monitoring forms, etc.	50.05
	Review Meetings	
	Support for Quarterly State level Review Meetings of district officers	2.40



	Quarterly Review & feedback meeting for exclusive for RI at district level with one Block MO.s, ICDS CDPO and other stakeholders	2.59
	Quarterly review meeting exclusive for RI at Block level	43.80
	Trainings	
	District level orientation training for 2 days ANM, Multi Purpose Health Worker (Male), LHV, Health Assistant (Male / Female), Nurse Mid Wives, BEEs & other specialist ( as per RCH norms)	
	Three day training of Medical Officers on RI using revised MO training module	
	One day refresher training of District RI Computer Assistants on RIMS/HMIS and Immunization formats under NRHM	0.30
	One day Cold Chain handlers training for block level cold chain handlers by State and District Cold Chain Officers and DIO for a batch of 15-20 trainees and three trainers	1.38
	One day Training of block level data handlers by DIO and District Cold chain Officer to train about the reporting formats of Immunization and NRHM	1.54
	Micro planning	
	To develop sub-centre and PHC micro plans using bottom up planning with participation of ANM, ASHA, AWW	6.50
	POL for vaccine delivery from State to District and from district to PHC/CHCs	20.00
	Consumables for computer including provision for internet access for RIMS / HMIS	0.91
	Injection Safety	
	Red/Black Plastic bags etc	10.08
	Bleach/Hypochlorite solution	4.31
	Twin bucket	3.45
	Any State Specific Need with justification	
	Temperature record books	0.60
	Chart on injection safety	0.67
	Strengthening of District Cold chain room	90.00
	Strengthening of Block cold chain room	14.00
	Extra incentive to District level cold chain and vaccine manager	10.80
	Hiring of pharmacist for cold chain and vaccine management at State level	4.60
	best 2500 village 8 person per@200/-	40.00
	Five best sub centres per district receiving prize money of Rs. 1100 for more than 90 percent coverage of fully immunised children below one year of age	0.99
	Three best PHCs per district receiving prize money of Rs. 2100 for more than 90 percent coverage of fully immunised children below one year of age	1.13



	One best block of each district receiving prize money of Rs. 51000 for more than 90 percent coverage of fully immunised children below one year of age	9.18
	Three best districts will receive an award citation worth Rs. 21000	0.63
	Verification of claims for best performance	4.00
	WIC installation at Janjgir Champa and Sarguja districts	10.00
	Solar Electrification on Salva Judum camp	50.00
	<b>Total Immunisation Part -C</b>	<b>973.70</b>
	<b>Part- D</b>	
<b>D</b>	<b>NIDD</b>	
	Establishment of IDD Control Cell	4.50
	Establishment of IDD monitoring Lab	0.00
	Health Education and Publicity	3.00
	IDD Survey	1.50
	Cord Blood Test	6.50
	<b>Total</b>	<b>15.50</b>
<b>E</b>	<b>Integrated Disease Surveillance Project</b>	
	Staff Salary	148.48
	Training	65.94
	Operational Costs	109.34
	4. New Innovations	4.50
	5. IEC	23.00
	6. Swine Flu / Epidemic Situation	38.85
	<b>Total</b>	<b>390.11</b>
<b>F</b>	<b>NVBDCP</b>	
	NVBDCP Activity under NRHM for State/district(DBS)	
	Human Resource like(for non WB districts) MPW, VBD, MTS, LTs,DEOs,F&LA	700.50
	ASHA	8.00
	NAMMIS	1.00
	IEC	20.00
	Training	3.00
	Central Lab	23.20
	Procurement of essential material, equipment & other operational Exp.	234.78
	Sub Total (DBS)	990.48
	Additional Support under World Bank for Project State/District	
	Human Resource(for WB districts)GIS-DE,IC,Acct.,SA,VBD,MTSs,LTs,DEOs,F&LA	177.99
	Capacity Building in project area Training+IEC+Strengthening cost +Seminar + Meeting & workshop	
		254.21
	Mobility Support	69.20



		501.40
	Sub Total (World Bank Supported)	1491.88
	Grand Total Malaria (DBS+WBS)	8745.82
	Budget for Commodities	13221.46
	<b>Grand Total Including Commodities</b>	
	<b>Filarial Programme</b>	
	Planning and preparatory meetings for ELF	2.00
	Training and capacity Building for different tiers of Health Personnel	27.70
	Mapping to estimate filarial endemic	9.00
	Drug delivery component for DEC MDA	47.20
	IEC	27.00
	Monitoring & Independent evaluation	5.25
	Hydrocoele Operation	9.00
	<b>TOTAL FILARIA</b>	<b>127.15</b>
	<b>G. NLEP</b>	
	Staff for State Leprosy Unit/ Cell	7.85
	Staff for District Leprosy Unit/ Cell	11.66
	ASHA incentive	32.00
	Supportive Medicine, Laboratory reagents & equipments and printing of forms etc.	9.36
	POL & Vehicle maintenance	19.70
	State & Peripheral level	50.00
	Training 4 days (Rural & Urban)	9.56
	Re-orientation for MO – 2 days	9.52
	Training Staff 3 days	14.01
	Lab Technician – 5 days	1.21
	Study Materials	2.82
	MCR footwear, Aids and appliances	7.65
	Patient Welfare & support to Govt. Hospitals	15.00
	Townships	6.84
	Medium cities - I	2.40
	Review meeting	4.92
	Travel expenses	3.20
	Office expenditure	4.06
	Consumables	3.20
	Cash Assistance (Table : 13)	20.00
	<b>Total</b>	<b>234.96</b>
	<b>H. NPCB</b>	
	GIA For Strengthening of Medical Colleges @ Rs.40 Lakhs	40.00
	Strengthening of District Hospitals @ 20 Lakhs	80.00
	Up gradation of Sub-District hospital/community health center @ Rs.5 Lakhs	80.00
	Restructuring Vision Centers at PHC/ Voluntary Org @ Rs.50000	18.00



	Non recurring GIA for NGOs @ Rs.30 Lakhs	30.00
	Appointment of Ophthalmic Surgeon (Salary of Rs.25000/- P.M.)	15.00
	School Eye Screening Programme	39.60
	Training	19.68
	IEC	58.10
	Maintenance of Ophthalmic Equipments	16.00
	Free Cataract Operations @ Rs.750 per case	450.00
	Free Cataract Operations(Incentive to Mitnin @ Rs175 per case	70.00
	Other Eye Diseases@ Rs.1000 per case	10.00
	Private Practitioners	7.50
	Management of State Health Society, Remuneration, other activity & Contingency	14.00
	Recurring GIA to Eye Donation Centers	3.75
	Recurring GIA to Eye Banks	2.50
	Procurement of Ophthalmic Equipments	135.00
	Appointment of Ophthalmic Assistant (Salary of Rs.8000/- P.M.)	9.60
	Non Recurring GIA for Eye Wards & Eye OTs@ Rs.75 Lakh	168.00
	Non Recurring GIA for Mobile Ophthalmic units with tele-network@ Rs.60 Lakhs	0.00
	Eye Donation Centers@ Rs.1 Lakh	6.00
	Eye Donation Counselor(Salary of Rs.10000/- P.M)	4.80
	Training of MPW Male & MPW Female	32.11
	Incentive to School Teachers	5.00
	Performance Bonus to Eye Surgeons	20.70
	Transportation of Eye Surgeons & Team	18.42
	<b>Total</b>	<b>1353.76</b>
<b>I</b>	<b>RNTCP</b>	
	Civil Works	78.76
	Laboratory materials	39.55
	Honorary*	43.63
	IEC/Publicity	69.67
	Equipment maintenance	15.12
	Training**	76.07
	Vehicle maintenance & POL	33.93
	Vehicle hiring	52.24
	NGO/PP support	76.23
	Miscellaneous	39.39
	Contractual Services	438.30
	Printing	36.56
	Research and studies	0.00
	Medical Colleges	20.21
	Procurement-Vehicles	7.00
	Procurement-equipment	64.25
	<b>Total</b>	<b>1090.92</b>



	<i>Tribal activities</i>	73.32
	<b>Grand Total</b>	<b>2255.15</b>
<b>J.</b>	<b>Non-Communicable Diseases</b>	
	National Cancer Control Programme (NCCP)	112.53
	National Tobacco Control Programme	19.08
	National Programme for Prevention & Control of Diabetes, Cardiovascular disease & stroke (PNDCS)	115.40
	<b>Total</b>	<b>247.01</b>
	<b>Total Part - D</b>	<b>17845.10</b>
	<b>G. Total (Part A+B+C+D)</b>	<b>56533.34</b>
	<b>Plan for Left Wing Extremists' affected area</b>	<b>15051.10</b>

7.5 (15,000/-)  
6.5 (13,000/-)







